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ORGANIZED MEDICINE IN ONTARIO

J. W. GROVE

A STUDY FOR
THE COMMITTEE ON THE MEDICAL ARTS
1913





ONTARIO

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THE COMMITTEE ON THE HEALING ARTS
1969

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FOREWORD

The Committee on the Healing Arts was established by the Province of Ontario, Order in Council 3038/66, dated July 14, 1966.

In March 1967, the Committee commissioned Professor J. W. Grove, Department of Political Studies, Queen's University, to undertake a study on medical organization in Ontario. The following is the study prepared by Professor Grove and submitted to the Committee in August 1968.

The statements and opinions contained in this study are those of Professor Grove, and publication of this study does not necessarily mean that all the statements and opinions are endorsed by the Committee.

I. R. Dowie, Chairman

Horace Krever

M. C. Urquhart

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J. W. G.

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Medicine is, in truth, such a blend of science and of art, of conceptions and misconceptions, of realism and idealism, of fact and fancy, that it is perplexing to try to keep its parts in order and continue to strive for the greatest good for the greatest number.

—*Editorial in the New England
Journal of Medicine, June 1, 1967.*

Part One: Introduction

Chapter 1 Trends in Medical Science and Medical Practice

Cascellius extracts an aching tooth. Hyginus burns away the hairs that hurt the eyes . . . Hermes is a very Podalirius in curing hernia; but tell me, Gallus, where is he that can help my harassed person?

—Martial, 1st century A.D.

The subject of this study is the medical profession in Ontario — how it is organized and how it operates — and, particularly, how this organization affects the supply, training, education and practice of doctors in the province; their relations with each other, with the other health professions and with the government; and their dealings with their patients. The focus is on professional organization, not on the substance of medical science, medical education or medical practice as such. Nevertheless, the two are inescapably linked. Many references to substance will be made as the report proceeds. By way of background, this chapter reviews some recent trends in the science and practice of medicine. Chapter 2 introduces some considerations about professional organization, in general, in modern society and about the profession of medicine in particular.

Nature of the Medical Profession

One of the most dramatic changes that has taken place in the past forty years is the revolution in medical science. The World Health Organization has estimated that an article on medical science is published somewhere in the world every twenty-three seconds. The proportion of medical knowledge that is based on empirical inquiry and systematic research rather than on rule of thumb increases daily, and the total amount of medical knowledge is now far beyond the capacity of any one person to absorb. Moreover, the pace of change is such that new knowledge quickly becomes out of date. Specialization is inevitable, but specialization itself contributes to the advance of knowledge and increases the rate of obsolescence. These trends pose serious problems for medical educators and medical practitioners: how to keep abreast? how to select what is most important?

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how to reduce the time-lag between discovery and application? These dilemmas are not, of course, peculiar to medicine: they are almost universal in a society that is devoted to the pursuit of science and technology. There are, however, certain unique features.

One of the hallmarks of a profession is that it possesses both a body of skills and a systematic theory. It is perhaps not unfair to argue that traditionally medicine has been skill-oriented rather than theory-oriented. Behind these skills there was a body of knowledge that was very highly developed, even before the recent immense advances in medical science; but it was not, in general, systematic theory. It was *lore*, in the best sense of the word: something the medical student had to know (or at any rate know about) before he could practise. And even if he went on to specialize, he was still absorbing lore. There is an important sense in which the concept of a body of knowledge, even one that is being continually added to, is fundamentally unscientific; and a sense, therefore, in which the *modus operandi* of the professional man is diametrically opposed to that of the scientist. The scientist does not generally suppose (popular opinion to the contrary) that what he is doing is adding incrementally to a body of established "truth"; rather he believes his task is to question established "truth", to be iconoclastic, to try to falsify, to start from things he does not understand rather than from those he does. This is not, on the whole, the professional way of thinking, and it is not the way in which traditionally the medical man has gone about his business.

There is evidence that this is now recognized by many medical educators. The way they express it is that they want to produce doctors who "know how to think", "know how to solve problems", "know how to go about finding out", rather than doctors who, to put it crudely, "go by the book". But there is a dilemma here, and perhaps it is one facet of the tension that exists at present between the medical educator and scientist¹ and the practical (and practising) physician. The latter must inevitably base himself on "cases" (in the past the core of medical training, including internship), and "cases" are what the doctor sees. The medical scientist, on the other hand, is not concerned with "cases" but with experiments, statistical correlations using large numbers, and testable theories. Not everyone is happy about this. There are many who argue that "basically, medicine has not changed", by which they may be taken to mean that there are, as there always have been, certain medical skills (sometimes, admittedly, very complicated ones) that have traditionally been reduced to a kind of routine and learned by a kind of rote: basic drills that must be mastered, routine procedures that must be gone through, for example, in examining and diagnosing a patient, together with a hard core of facts — all of which (they say) is being progressively neglected in modern medical training. This was put to us many times, most forcefully perhaps by a surgeon who argued that "today's medical student can give you three theories about a complaint and tell you eight ways to treat it, but not which one to use on the patient in front of him".

¹Or "ivory-towered theorist", to use a phrase that we have often heard from practitioners.

Recent Advances

It is not easy for the layman to single out the most significant recent advances in medicine; but they would surely include at least the following:

- 1) The “drug revolution” — the application to medical practice of advances in pharmacology, microbiology and immunology; the development of “miracle” drugs, hormone preparations, new vaccines. This has led to the virtual elimination of many previously serious diseases, to a reduction in the hazards or incidence of others, and to a transformation of some major illnesses into minor disorders. Yet, at the same time, it has raised a host of new problems: for example, the dangers of side-effects and wrong or overprescribing by unskilled practitioners. It has also brought the degenerative disorders of middle age into greater prominence so that preventive medicine has taken on a new aspect.
- 2) The growth of geriatrics as a branch of general medicine — raising serious problems concerning the rehabilitation and welfare of the elderly.
- 3) Developments in paediatrics and obstetrics — which have greatly reduced infant and maternal mortality, but have resulted in the survival of an increasing number of mentally and physically handicapped children.
- 4) Advances in the understanding and treatment of mental illness — for example, the contribution of drug therapy to the shift of emphasis from primarily custodial to primarily outpatient and community care.
- 5) Spectacular progress in surgery, much of it made possible by modern anaesthetic techniques — replacement surgery using artificial materials as well as human tissue; a shortened period of in-patient treatment for the simpler types of general surgery; the reduction of some previously serious operations to relatively minor procedures; increasing stress on the surgical team.
- 6) Finally, great progress in diagnostic and investigational services making use of advances in clinical pathology and diagnostic radiology.

None of this, of course, has taken place in a social vacuum. The population has been growing rapidly by natural increase and immigration; it is becoming more and more urbanized; it has been getting itself injured more often and in greater numbers in industrial and automobile accidents. The patient himself is changing. He is now more sophisticated; his expectations and demands are greater;

he is more affluent; his attitude to specific illnesses and to health problems in general has been transformed. As Lord Platt has said:

Although many will tell you of astounding developments in medical science, very few ever seem to refer to the fact that most of our patients have changed out of recognition. Even in my own time the hospital population which I knew as a young man was inadequately clothed and fed and housed and usually dirty and ignorant and ill-informed Patient, grateful and undemanding, these people would wait long hours for the benefit of the medical skill which (was) charitably provided for them To-day . . . I meet a different population . . . most have views and opinions which with a little encouragement they are not afraid to express . . . they rightly feel entitled to a standard of service far ahead of what a former generation would have expected.²

At the same time, changes have been taking place in medical practice. Responsibilities that were formerly the physician's have been transferred to others. In the hospital he is assisted by many qualified people trained in special paramedical skills. Much that was formerly done for the patient in the hospital can now be done while the patient lives at home — given suitable community care facilities.

In one sense, therefore, the doctor's job has been simplified. But it has also become more complex. "Big" medicine requires highly complicated procedures and involves the cooperative efforts of teams of specialists. Often it requires large and expensive facilities. The scope of medicine has greatly increased: more can be diagnosed, more can be cured, more can be prevented and more can be treated. Partly in response to this, the demand for medical care has risen enormously. Combined with the growing affluence of the mass of the people and the spread of medical insurance plans, this increased demand raises many problems. The *demand* for medical care is not necessarily, indeed is not usually, coincident with medical *need*. When is a service medically necessary? Is it medically adequate when it is given? Who is to decide? And by what means? In the Canadian hospital an attempt has been made to determine overservicing and inadequate servicing by establishing "quality controls" under the supervision of the medical staff and by improving medical record keeping and medical audit.³ Outside the hospital machinery is still very rudimentary.

Much modern treatment is potentially dangerous. The need for great precision in its administration calls for doctors who are skilled and knowledgeable in depth in rather narrowly defined areas of competence. But adequate care also demands doctors who are sufficiently aware of the implications of a whole range of medicine ("generalists" in the proper sense — not amateurs, "gifted" or otherwise) to be

²Sir Robert (now Lord) Platt, *Progress Report to Thomas Linacre, Reflections on Medicine and Humanism*, The 1963 Thomas Linacre Lecture. (Linacre was the Father of the Royal College of Physicians of London (1518), and its first President.)

³It should be noted that even this can be applied much more successfully to surgical procedures than to other kinds of medical care.

able to know when, how and where to make use of highly sophisticated techniques. The drug revolution, for instance, has altered the pattern of medical practice by shifting to the care of the general practitioner cases that previously required hospitalization; but at the same time, by making it more difficult for him to keep up to date, it has increased rather than diminished his need for specialist guidance.

Nor does the impact of scientific knowledge come from the natural sciences alone:

Although the systematic study of medical sociology is new and relatively unorganised it has already produced an extensive and growing literature, so that distinctive fields of study have been marked out with specialists, both in medicine and sociology, devoted to each. Some of these specialists are concerned with epidemiology, with the configuration of disease by social categories; others with the way in which the social environment affects the process of restoring patients to their normal social functions. Other scholars have studied the institutions of medical care, the organisation of the medical profession itself, and the systems of medical education.⁴

It is likely that the application of the social sciences to medicine will become even more important as time goes on. The insights that they provide into the nature of social processes, the structure of societies, and the relationships between individuals within society are a necessary foundation for the effective practice of medicine, curative as well as preventive.

The concepts of the social sciences enable us to analyse social relationships in the practice of medicine, and to trace in the patient those social experiences which most affect his behaviour, symptoms, and perception of illness, and the form of the illness itself. Moreover, sociological insight assists the clinician to discern those social influences which affect his own behaviour, his interpretation of illness, and his care of patients.⁵

Structure of the Profession

Developments in the medical arts and the growth of medical science have had profound effects on the structure of the medical profession. New specialisms and subspecialisms proliferate; some older specialties decline. At present, cardiac surgery is an entirely new field; psychiatry, pathology and anaesthesiology are assuming ever-increasing importance; while pulmonary surgery is less significant than it used to be.

Specialists (become) a group of experts with special skills, training and equipment and with a growing sense of their own specialist identity. Beside them the general practitioner . . . uneasily (surveys) his future role.⁶

The balance between the specialist and the general practitioner shifts markedly in favour of the former.

⁴M. W. Susser and W. Watson, *Sociology in Medicine*, Oxford University Press, London, 1962, p. ix.

⁵*Ibid.*

⁶Rosemary Stevens, *Medical Practice in Modern England*, Yale University Press, New Haven, 1966, p. 3.

In Canada, between 1955 and 1965, the number of specialists almost doubled while the number of general practitioners increased by only about 4 per cent. In the same period the population increased by 18 per cent and the total number of doctors by about 36 per cent. One significant development has been the rise of non-referral specialist practice in such former preserves of the general practitioner as paediatrics, obstetrics and geriatrics; and the spread of group practice could well accelerate this trend. But the shift of emphasis is not to be explained solely in terms of the growth of medical art and science. There are economic considerations (for example, the specialist can charge higher fees than the general practitioner and, with the advent of medical insurance, he can get them from more people). The declining prestige of general practice, too, is a major contributing factor.

Today there is a decreasing number of general practitioners dealing with more and more patients. In the United States the general practitioner has almost disappeared; he has been eliminated in the U.S.S.R. and in many other Communist countries. He is still the cornerstone of the British National Health Service; but even there he faces many of the problems that are faced by his counterpart in Canada. There is a failure both to attract the medical student *to* general practice and to hold the young doctor *in* general practice. He has been displaced from the centre of the medical universe. At one time he was the only doctor the patient ever saw, except when the doctor chose to "call for a second opinion" (brought in a consultant specialist) or when the patient was hospitalized. All that has changed. The public, especially the middle-class public, demand and make much greater use of the specialist; and the general practitioner feels both his status and his social worth sharply reduced. In a sense, medicine appears to have passed him by. As his numbers decline relative to demand he is more and more hard-pressed, and he grumbles about his patients and their lack of consideration. (In one recent British study,⁷ half the G.P.'s estimated at least a quarter of their office consultations were unnecessary.) In Canada, faced with the prospect of universal medicare, he fears that his status and working conditions will deteriorate even further, overlooking the point that it may well have been the National Health Service that has kept the British general practitioner in business — for there his existence is guaranteed, whereas in the United States, where the test of the market has been allowed to operate, he has been almost driven out.

Yet in spite of medical mythology about "the good old days" and the decline of the doctor-patient relationship, studies have shown that patient satisfaction with the general practitioner is high. The study by Margaret Wilson and Malcolm Hill⁸ of patients in Hamilton, Ontario showed that 91 per cent preferred to receive attention from their own doctor because they had more faith in him. Asked "If

⁷Ann Cartwright, *Patients and Their Doctors, A Study of General Practice*, Routledge, for the Institute of Community Studies, London, 1967.

⁸Margaret Wilson and Donald Malcolm Hill, *A Study Concerning Family Practice and the Changing Role of the Family Physician*, McMaster University, mimeo., 1966.

you went to a clinic and were told you would have to wait a couple of hours to see your doctor, would you wait or see another doctor?", 57 per cent said they would wait. Two-thirds said they would rather have a baby delivered in hospital by their own doctor than by an obstetrician, and 96 per cent said they would prefer their own doctor to a strange one if they had an embarrassing medical problem (such as venereal disease) to discuss. In the Cartwright study of British patients and their doctors, 82 per cent of the men and 87 per cent of the women said they preferred their own G.P. to direct access to a specialist. When asked whether they would rather see another doctor in a group straight away or wait about half-an-hour (sic) to see their own doctor, 45 per cent of the men and 60 per cent of the women said they would wait. Forty per cent of both men and women said they would have no reservations in talking to their doctor about general family problems. In another recent British survey,⁹ patients were asked how satisfied they were with their last visit to their G.P. Eighty-three per cent said they were very satisfied, 12 per cent were fairly satisfied and the balance of 5 per cent were either not very satisfied or very dissatisfied. In Britain, 68 per cent of Miss Cartwright's patients had been with their doctors for more than five years; in Hamilton, Wilson and Hill (working with a much smaller sample) found 72 per cent in this category.

Obviously many more studies are needed before we can say with confidence that we have a reliable picture; but there appear to be grounds for doubting the prevalent medical-political view that the old doctor-patient relationship is dead, killed by the modern affluent patient engaged in a ruthless hunt from doctor to doctor for the remedies he is determined to get. We cannot, however, disregard this attitude, which may reflect the doctor's feelings much more than it does the patient's. Two recent studies throw some light on this: the study of British general practitioners by Ann Cartwright, and the study of the general practitioner in Ontario and Nova Scotia by Dr. K. F. Clute.¹⁰

In the Cartwright survey, general practitioners were variously reported as saying: "we are swamped with trivialities", "the G.P. has no status because he doesn't do medicine — 90 per cent of our work is with 10 per cent of our patients", "people have an increasing belief that they have a right to a doctor's services for anything at any time of day or night and can have him over a barrel if he doesn't do what they want", and "not everyone is prepared to be a doormat". Asked for their views on the statement that "patients nowadays tend to demand their rights rather than ask for help and advice", 22 per cent strongly agreed; 34 per cent

⁹Research Services Survey, sponsored by *New Society* and reported in that journal, October 19, 1967, at p. 545.

¹⁰K. F. Clute, *The General Practitioner*, University of Toronto Press, Toronto, 1963. Dr. Clute's sample was much smaller than Miss Cartwright's (only 56, compared with Miss Cartwright's 422).

agreed, but less strongly; 10 per cent strongly disagreed; and 20 per cent disagreed less strongly. There was a definite correlation between their stance on this issue and others: for example, their views on the "triviality" of office visits; their attitude to remuneration, to bureaucratic regulation, and (interestingly) to the social class of their patients ("the doctor may accept that working-class people feel unable to cope with certain 'minor' conditions, but resent it more when middle-class people react in the same way"). Yet 52 per cent of the doctors enjoyed general practice "very much" and 37 per cent said they enjoyed it "moderately"; only 9 per cent "not very much" and 2 per cent "not at all".

In the Clute study, many of the doctors studied thought the general practitioner has less prestige in the eyes of the public today than he merits: "the public is more specialist-conscious", "general public education has destroyed the myth of the G.P.", "the physician's cloak has been removed by knowledge". The tendency of patients covered by some form of insurance to look upon a doctor "as a civil servant ready to jump at their bidding" was also given as a reason for the decline.

Perhaps the matter is best expressed, in summary, by Dr. Ellis:

Every country and every individual becomes more conscious of medicine, and more demanding of it, *tending usually to over-rate its power and to under-rate its dangers*. In consequence, the profession tends to be more respected by the people, who at the same time have become much more critical of it.¹¹

The "average doctor" tends, perhaps, to react rather violently to the criticism while overlooking (or ignoring) the real core of respect. The "average patient" tends to blame the doctor for not doing things that are beyond his capacity, while maintaining an apathetic or compliant stance towards things that could be improved.¹²

Trends in General Practice

The relative decline in the number of general practitioners is one fact; their maldistribution is another. Ontario as a whole fares well by comparison with other provinces; but *within* Ontario there are some acute problems. Generally, the small towns and rural communities do badly, and in some places when the sole doctor has retired, or died, or moved away, or merely "had a coronary", there is great difficulty in replacing him. The reasons are not hard to find: lack of daily contact with other doctors, the doctor's wife does not like small-town life, schools are inferior, there is a long way to go to hospitals and consultant services, cultural

¹¹J. R. Ellis, "The Profession and the People", *Journal of Medical Education*, Vol. 39, January 1, 1964. Emphasis added.

¹²Compare two of Cartwright's patients: "Medical research and all that has improved. People look up to a doctor now. I do for one, I really admire him"; but "I use Sloan's liniment for backache. I don't want to go to see my doctor unless I'm really ill. I don't want to trouble the poor man." Ann Cartwright, *op. cit.*

amenities are lacking. Yet the central areas of the large cities are also hard hit. Scarcity of hospital privileges has been blamed; but dislike of metropolitan living with all its problems of housing, travel, parking, high costs, including high office overheads, air pollution and general strain, is not to be discounted. There are no easy solutions to this dilemma. The concept of freedom to choose one's place of work (as strongly held in "nationalized" British medicine as it is in "free enterprise" Canadian medicine)¹³ makes it impossible to *direct* the rational distribution of doctors in relation to local need, and resort must be had to persuasion and economic incentive.

In the final analysis, however, the future of the general practitioner depends upon the future of general practice as a professional skill. If the skill does not change in response to changing conditions, the general practitioner may well disappear. It is by no means self-evident that this would be a good thing; indeed much of the evidence from the United States suggests the opposite. But it is now quite widely accepted that if general practice is to survive it must be as a distinctive activity and not merely (as it so often tends to be today) as an inferior substitute for specialist treatment. The reawakening of interest in the idea of the family physician and the development of new concepts of family practice point towards a reappraisal of the traditional role.

It is widely agreed, also, that the day of the solo practitioner is almost at an end. A 1967 survey by the CMA found that about 30 per cent of all practising doctors are engaged in a group practice of some kind.¹⁴ Only about 13 per cent, however, are in places of under 2,000 population. Though this is not surprising, it is paradoxical from the point of view of public policy since it is often precisely in these places that the single-handed doctor faces his greatest difficulties: loneliness, lack of relief, inability to get away for refresher courses, and so forth. Group practice is resisted by some doctors who fear overseeing by colleagues (and even by non-medical members of the group team such as nurses and social workers) and who are apprehensive lest the new idea be allowed to upset the traditional relationship between the doctor and his patient. Nevertheless it seems certain that group practice will continue to grow and will ultimately replace solo practice altogether. Studies have suggested that the patient would be willing to travel quite long distances to a group practice provided he could have a personal physician when he got there. In the Hamilton survey, for example, 33 per cent said they would like their doctor's office located in a clinic where there were specialists present, and 60 per cent said they would like it in a clinic where there were laboratory and x-ray facilities. In any event, it is likely that attendance at a group practice clinic will prove more attractive to the patient than the rather anonymous alter-

¹³One of the pervasive myths put about by North American doctor-politicians is that in Britain the doctor can be directed to wherever the government wants him to go. This is quite false.

¹⁴Group practice, however, is an ambiguous term; it may cover anything from the two-man partnership to the large clinic employing twenty or thirty doctors, or more.

native that is increasingly being forced on him in some places — attendance at the emergency department of the local hospital. It is also possible that the clinic will prove more attractive than the hospital to the married nurse or married social worker because of its greater convenience and, perhaps, its greater prestige.

The changing role of the hospital emergency department requires brief elaboration. Traditionally, the emergency department was for the treatment of minor accidents and for the admittance of the seriously ill or injured on their way to a bed in the hospital. It is still used this way (for an ever-increasing number of accident cases), but it is more and more frequently used also to treat patients who have no regular doctor or whose own doctor is not available (at weekends, on holidays and at night). The first of these categories (those without a doctor) is a function partly of increasing mobility and partly of new immigration, since many of these patients, particularly in the large urban centres, are new arrivals. There is also a growing tendency for general practitioners to refer their patients to emergency departments for treatment where they would once have treated them in their own offices. All this places heavy pressure on the facilities and staff of hospital outpatient and emergency departments, the more so since it occurs in an irregular (and even a seasonal) manner, with occasional peaks and rush-hours. In the past the service has been provided in the larger hospitals by internes and residents, and in smaller hospitals by general practitioners in return for hospital privileges. The practice of the smaller hospitals is now spreading to the larger ones, mainly because of the increasing demand for service and the acute shortage of residents and internes.

There is an interesting trend towards using the emergency department as a kind of general practice clinic. This has some advantages if it is properly organized, but it also creates problems. One of these is financial: if a general practitioner attends the patient, it is he who gets the fee, not the hospital; whereas if a member of the hospital staff attends the patient, there are perplexities (where medical insurance is involved, as is now usually the case) about the proper use to which the monies should be put. Thus there are strong pressures, financial as well as administrative, for the establishment of separate, full-time, fully hospital-controlled emergency and outpatient departments. These can be (and some of them are) organized as a kind of group practice staffed by general practitioners who have been persuaded to give up outside work.¹⁵

¹⁵See, for example, the interesting experience of the Emergency Department of the Virginia Alexandria Hospital in the United States as briefly related by Dr. D. L. Kippen in his paper, "The Role of the Profession in the Emergency Department", presented to the CMA Centenary Conference, May 1967. In this paper Dr. Kippen also discusses a number of alternatives that have been tried.

For an account of an experiment at Scarborough General Hospital in Toronto see: B. Johnston and W. R. Hodgkiss, "A New Concept in Emergency Service", *Ontario Medical Review*, July 1965, p. 487.

Effects of Bureaucratization

Changes in medical knowledge and practice have had both centralizing *and* decentralizing effects. On the one hand there is a trend towards concentration of specialized but integrated services in community hospitals, large clinics, health centres, and so on; on the other hand, there is a rising demand for the dispersal of treatment outside the hospital through the provision of personal health services in and from the home, using community-centred agencies. Either way the effect (for many patients) is to take away the convenience of close proximity to the physician's surgery, and (some say) to weaken the traditional doctor-patient relationship based on an intimate personal knowledge of the patient and his family.

In Canada the vast majority of the people live in or around large urban centres, and it is in these centres particularly that we may properly speak of the increasing hospital-centredness and bureaucratization of modern medicine.¹⁶ Scientific advance and the new medical technology mean, inevitably, that medicine becomes more and more hospital-centred, since it is there that the elaborate equipment, specialized skills and complex procedures must be grouped. Until quite recently the hospital was the last refuge of the sick and homeless and the dying poor; today the indigent patient has almost disappeared, and the modern hospital has become the dominant institution in medical care as well as in training and research. At the same time, paradoxically, a very small proportion of the people seeking medical attention actually require hospitalization (some put it as low as one per cent).

With increasing specialization the same patient may be dealt with by several (occasionally many) doctors, both inside and outside the hospital, as well as by other people in professions supplementary to medicine and in welfare agencies. One result is that responsibility for the patient's care is diffused and the goal of treating "the whole patient" may be lost. For example, as Susser and Watson put it:

It may not be clear whether responsibility for a patient rests with the orthopaedic surgeon who advises physiotherapy for an effusion of the knee-joint, which he has diagnosed, or with the specialist in physical medicine who is in charge of the physiotherapists who give the treatment.¹⁷

¹⁶The vast proportion of hospital expansion in Canada has taken place in the last twenty years. In 1964 there were about 1,450 hospitals in Canada with a total of 200,000 beds (1,300 general or allied special hospitals with 130,000 beds; 100 mental hospitals with 65,500 beds; and 50 TB hospitals with 6,300 beds). They employed about a quarter of a million full-time people or about 4 per cent of the labour force. The rough proportions were: medical, including internes and residents and full-time physicians and surgeons, 3.5 per cent; nursing, including orderlies and ward aides, 53.5 per cent; paramedical, including hospital administrators, medical records librarians and medical and social workers, 7 per cent; all supporting staff, 36 per cent.

Between 1948 and 1958 the full-time staff of general hospitals increased by half; between 1958 and 1962, by a further third.

¹⁷Susser and Watson, *op cit.*, p. 152.

It is considerations like this that have led doctors, particularly those in social medicine, to put forward arguments that emphasize "human needs".

The increasing bureaucratization of medicine manifests itself in many ways: for example, in the rise of professional associations attempting to exercise some control over doctors through their own hierarchy of "office-holders", usually elected by the rank and file of the membership; in the increasing employment of doctors in large-scale organizations, where they no longer work for themselves; in the increasing subjection of medicine to rules and regulations, some of them made by public governmental authorities, others by the profession itself; and in the growing pressure to test capacity by examinations and guarantee it by proliferating certificates of technical competence.

Within the hospital, the increasing complexity of clinical techniques aggravates the growing problem of rules and regulations: rules, for example, governing precisely what a nurse may or may not do with or without the direction of a physician, directions to hospital attending staff about the keeping of proper medical records, rules for internes.¹⁸ Many of these regulations reflect the need to run the hospital in an orderly and rational manner; but some of them stem from the fact (already discussed) that the new diagnostic and therapeutic procedures are a potential hazard to the life of the patient (and in some instances to the medical staff as well). Moreover, in spite of the tradition that no doctor has authority over another doctor (a matter discussed more fully in Chapter 2 and later in this report), in practice, certainly in hospital practice, doctors *are* increasingly required to accommodate their behaviour to the de facto authority of other doctors acting in official capacities. Further, governmental rules and regulations become daily more important with the establishment of bodies such as the Ontario Hospital Services Commission and OMSIP and the increase in public financial support for the health services. Nor is the general practitioner exempt, and this arouses particular resentment. As one physician put it to the Conference celebrating the Centenary of the Canadian Medical Association:

Demands are made on us for certificates for missed work, government and business demand that we make out pieces of paper certifying workers off work because of illness and in many instances employees' pay is held up pending the receipt of such certificates. We are forced to police many of the employment practices of business, disability payments, welfare payments, workmen's compensation awards, and the like. With medicare our most important instrument will be the ball-point pen. We are gradually being forced to conform to directives issued by other people instead of thinking and working independently.¹⁹

¹⁸For example, the *Interne's Manual* issued by the Toronto East General Hospital consists of eighty loose-leaf pages of instructions.

¹⁹Dr. J. A. McMillan, "Factors Influencing Utilization of Medical Care", *Medical Care Insurance and Medical Manpower*. Manuscripts of the conference of the Canadian Medical Association, Montreal, Quebec, June 19-23, 1967.

The Hospital Environment

A brief further comment is necessary on the changing role of the doctor in the hospital. As we shall see later, the hospital has almost ceased to be a place where private practitioners voluntarily give part-time service to the care of indigent patients. There are now few indigent patients, and more and more full-time (or almost full-time) doctors. The hospital is fast becoming a centre for the delivery of health care in which the doctor takes his place as one professional among many. But the hospital is a curious kind of bureaucracy, with overlapping hierarchies: the medical staff, with its own organization; the nursing staff, and the paramedical and ancillary staff with theirs; and the lay administration, also increasingly professionalized. Managerially, hospitals are out of date, for they are still run largely on the basis of an outmoded paternalism of the medical profession. This is a universal fact, one which is leading some critics of contemporary hospital management to put forward new ideas, centring essentially on the notion of the hospital as an "arena" of medical care. In this "arena" there would be a highly pluralistic "negotiated order" (rather than a superior-subordinate structure) of professional people working together — not "under" but "around" the pivotal position of a hospital general manager or chief executive, a position that might or might not be filled by a medical man. In any event, he would not be seen as a man at the top of a management hierarchy, but rather as the focal point of an intricate communications system. In this sense, no one would "run" the hospital: it would "run itself" in relation to a multiplicity of developing patient needs and professional goals.

Chapter 2 The Profession of Medicine

Let us hold fast our profession.
—Paul, *Epistle to the Hebrews*, 4:14

The History of the Profession

Although medicine is one of the oldest of the arts, its existence as an organized profession dates only from about the middle of the nineteenth century. In the early years in English-speaking Canada, medicine was much influenced by what was happening in the "Old Country". There the great traditional professions of divinity, the law and medicine were still the pursuits of gentlemen educated in the classical manner. The physician was supposed, first and foremost, to be a man learned in the classics. Even as late as 1834, Sir Henry Hallford, President of the Royal College of Physicians of London, told a Select Committee of the British House of Commons:

I think a knowledge of both languages (i.e., Latin and Greek) and of mathematics is absolutely necessary with reference to the respectability and dignity of the profession.

The great challenge to this long pre-eminence of the gentleman in medicine came from the surgeons and the apothecaries.¹ Both were tradesmen in origin: the surgeon was a craftsman, originally associated with the barbers, and the apothecary was a shopkeeper. Some surgeons rose to great wealth and eminence, but they were for the most part self-made men. The apothecaries (who were the forerunners of the modern general practitioner) took the first bold steps towards organizing themselves in a new type of self-regulating occupation, a profession in the modern sense, while the surgeons made the first great new advances in medical knowledge. For the rising man who was unable to break into the charmed circle of the gentlemanly physicians, it had long been necessary, if he wanted more training than mere apprenticeship could afford, to look to Scotland or to the continent of Europe.

The first medical school in Canada was established in Montreal in 1824. It was to become the Medical Faculty of McGill University. In the same year came

¹And, in institutional terms, from the Scottish universities with their great medical schools, and from the English provinces where the strength of the apothecaries chiefly lay.

the first attempt to found a medical school in Upper Canada, but it was a failure. In 1843, however, when the embryonic University of Toronto was founded, one of the first acts of its sponsors was to set up a Faculty of Medicine. In that year, too, a second school was established in Montreal, with bilingual teaching and management; this was the forerunner of the Faculty of Medicine of the University of Montreal. Before that time, English-speaking Canadian doctors (at least those who sought qualifications) were likely to receive their training in Scotland (particularly at Edinburgh)² and/or (like their French-Canadian colleagues) from continental medical schools. Many doctors had little formal training, however, and some had none at all, beyond apprenticeship to a man who might or might not himself have been qualified. Some were "liberal gentlemen" (ministers of religion, for example), some engaged also in farming or trade. Many were former Army surgeons.

The first major breakthrough in professional organization in England came from the apothecaries, when after a long struggle the Apothecaries Act of 1815 was put on the statute book. This was a remarkable measure, in many respects far in advance of its time, for it gave statutory form to some of the basic tenets of modern professional organization in the English-speaking world. It empowered the Society of Apothecaries to determine the educational standards required for entry into their profession, to examine candidates, and to give or withhold certificates of qualification. Only those who passed the examinations (which, unlike many at that time, were genuine tests) could call themselves apothecaries, and unqualified persons were forbidden to use the title. By this Act, certifying power was bestowed by the State on a private organization. But the State did not forbid unqualified practice: it merely put certain obstacles in the way. Full licensing, backed by law—implying that kind of certification which absolutely forbids anyone to practise who is not certified—has never been introduced into the medical profession in Britain,³ though it has in Canada.

The notion of a profession, as we understand it today (at any rate in the Western world) and of which the apothecaries were an early example, is a typical product of nineteenth century ingenuity: a curious blend of trade, business, craft, medieval guild, trade union and (what the Victorian English called) "society for the promotion of useful knowledge". The reforms in medicine that evolved in the nineteenth century and which were paralleled by similar developments in the other ancient learned profession of law, as well as in the rising new professions such as

²Edinburgh, it is said, served as a model for almost all the early medical schools in North America, and it was the alma mater of many of their first professors. Edinburgh itself had by then adopted many of the methods of the great medical schools of Europe. Of 260 doctors whose biographies appear in Canniff's *History of the Medical Profession in Upper Canada from 1783 to 1850*, seventy were graduates of Scottish, forty-three of English, twenty-eight of Irish and forty of American universities. H. E. MacDermot, *One Hundred Years of Medicine in Canada*, McClelland and Stewart for the CMA, Toronto, 1967, p. 112.

³Nor is it ever likely to be, according to the Secretary of the General Medical Council (interview with the author, June 1967).

engineering, focused essentially on four major issues: the establishment of programs of education and training in a coherent body of skills leading to certificates of competence; public recognition of such competence, preferably with State backing; the right of the profession to regulate its own affairs, including entry to the profession and control over the conduct of its members; and collective defence of the interests of the profession against competing groups. The attainment of professional status thus demanded the creation of new institutions: "schools" in which the skills could be taught, preferably associated with the universities; licensing bodies; organizations for mutual help and collective defence (professional associations), such as, in medicine, the British Medical Association (1832), the American Medical Association (1847) and the Canadian Medical Association (1867); and "scientific societies" for the promotion of professional knowledge. In some cases the functions of these various bodies were combined in one association, though in this matter medicine has generally been notably pluralistic.

Development of Professional Ethics

Organization, a tendency to monopoly, mutual self-defence, and what are now called restrictive practices were to become the hallmarks of the new professions, as they had been for some centuries of the ancient guilds. But at the same time their developing sense of identity and mutual self-help overlay a form of practice that was both ruggedly individualistic and (at least within the profession) ruthlessly competitive. There were other important breaks with the past: for example, apprenticeship (the mark of a trade), though remaining important, but in radically altered form, in medicine was subordinated to training in an "academic" institutional setting. But there were also continuities, nowhere more apparent than in the matter of professional behaviour. The professional ethic, as it emerged towards the end of the nineteenth century, was based on the notion of a fundamental one-to-one relationship between the professional man and his "client", in which nothing was sold but a service was provided. The welfare of the "client" came first; money-making was a secondary consideration (the basis of remuneration was traditionally the fee—the amount of which was never discussed but which came increasingly to be customarily fixed, like the apothecaries' half-crown or the solicitors' six and eight-pence, or, later, based on a scale prescribed by the professional body). Since nothing was sold, there was to be no advertising, no touting for custom, and no price-cutting. The philosophy behind this ethic has come under strong attack from some recent critics of the professions⁴ who argue that it is nonsense—or at any rate, economic nonsense. The professions, they say, produce services for sale no less than dry-cleaners or the CNR. It has been plausibly, though no doubt somewhat cynically, suggested that the professional ethic was the result of an attempt on the part of the rising professional class to blend two quite different scales of values: the tradesman's, which the professional man was seeking to leave

⁴For example, D. S. Lees, *The Economic Consequences of the Professions*, Institute of Economic Affairs, London, 1966.

behind, and the gentleman's, which he was aspiring to espouse. Thus what came to be known as "professional ethics" was, in truth, a brand of business morality: the code gave a gentlemanly patina to what was essentially a matter of business like anything else.

Medicine as a Modern Profession

Social scientists have discussed, at almost tedious length, the fundamentals of the "professional orientation". First, we are told, a profession is characterized by universal standards, by objective criteria derived from a specialized body of knowledge: for example, there is a profession of medicine and its practice consists in applying principles with appropriate skill to particular cases. We have already mentioned this in the first chapter. Second, a profession is marked (it is said) by specificity of expertise—the professional is a specialized expert qualified to deal with problems in a strictly limited area: he is neither sage nor generalist. Third, the relationship between the professional and his client is characterized by "affective neutrality", or impersonality: thus all professional codes condemn emotional involvement with the client. Fourth, the professional's status is achieved, not ascribed: he "gets there" on merit. Fifth, professional decisions are not based on the practitioner's self-interest. Appendices are not supposed to be removed solely to keep the surgeon's family in comfort irrespective of their (i.e., the appendices) state of health.⁵ The service given is therefore related to need, not ability to pay. Sixth, the basis of authority is, *as between the professional and his "client"*, that the client does not know what is good for him whereas the professional does (this is one reason why the client's welfare is supposed to come before the professional's) and also that the client's *wishes*, as distinct from his *interests*, must not be allowed to influence the professional's behaviour; *as between professional colleagues*, self-control and the judgement of equals rather than hierarchy (all medical men, the eminent and the humble alike, are brothers, not superiors and subordinates). One pair of sociologists has expressed the last point as follows:

Professional control appears to have two sources. First, as a result of the long period of training undergone by the practitioner he is expected to have . . . internalised a code of ethics which governs his professional conduct. Second, this self-control is supported by the external surveillance of his conduct by peers, who are in a position to see his work, who have the skills to judge his performance, and who, since they have a personal stake in the reputation of their profession, are motivated to exercise the necessary sanctions. Professionals in a given field constitute a colleague group of equals. Every member of the group, but nobody else, is assumed to be qualified to make professional judgments . . .⁶

⁵The Royal College of Physicians of London was founded in 1518, in part "to curb the audacity of those wicked men who shall profess medicine more for the sake of their avarice than from the assurance of any good conscience" (these words are taken from the Charter).

⁶P. M. Blau and W. R. Scott, *Formal Organisations*, Routledge, London, 1963, p. 63.

It is often suggested that it is precisely the latter, the difference in social control, that is the basic feature that distinguishes professional from bureaucratic organization, the kind of organization we find in large-scale business and government.

There is a ring of (at least half-) truth about all this. Certainly these "characteristics" are an important part of the mythology of the professions, in medicine as elsewhere; but it takes little perspicience to see that some of them are (or should be) subject to modification in practice. The idea of specificity of expertise, for example, is all very well as long as it does not lead to the erection of artificial barriers: to the notion that it is *this* professional and *no one else* who can properly be permitted to practise in *this* area. This has relevance not only to the boundaries of subspecialisms *within* medicine, but also to the boundaries *between* medicine and other health professions: for example, the issue dividing doctors and dentists about "surgery of the jaw" and the dispute between doctors and chiropractors. The notion of "affective neutrality" between the professional and his client can hardly be said to apply at all to psychoanalysis, and it should perhaps apply only within certain limits to the family physician. Third, if medical service were indeed always related to need and not to ability to pay, it would not have been necessary to invent the British National Health Service and the debate in North America about medicare could have been avoided. Fourth, it may be suggested that the idea that the client never knows what is best for himself has probably buried a good number of patients in the long course of medical history; and no one has ever satisfactorily explained *why* the client's wishes should not be taken into account in forming a professional judgement. But the major reservations must be kept for the idea of "professional self-control". There is no doubt that it exists; but whether it functions quite as the social theorists (or the ideologists in the professions themselves, for that matter) suggest — or, even if it does, whether it is in the public interest that it should — is another question, to which we must now give some attention.

There is no doubt that what sociologists call "socialization" is, and always has been, of great importance as an aspect of the training of the physician. This is underpinned by much symbolism and ritual, of which the stethoscope, white coat, Hippocratic Oath and esoteric jargon⁷ are only the more obvious examples. Medicine has a very strong set of social values (basic beliefs): its own norms or guides to behaviour in social situations (for example, how to behave towards other members of the profession and towards patients in the office or at the bedside, how to identify superior competence, how to behave towards subordinates such as nurses in an institutional setting, and so forth). It has its own style of life, part of which is shared with other professionals (for the professional man there are no "regular" hours of work, the distinction between work time and leisure time is blurred⁸) but part of which is peculiar to medicine (doctors tend to be very "clannish" and to

⁷"I ask my medical readers to bear with me when, now and then, I mention 'removal of the bladder' instead of 'cholecystectomy'" K. F. Clute, *op. cit.*, p. vi.

⁸The professor is the best example of this, sometimes to the point of absurdity.

live rather to themselves). In other words medicine has its own distinctive sub-culture and, to succeed, the aspiring doctor must make an effective (and an *affective*) adjustment to it.

Mastery of the underlying body of theory and acquisition of the technical skills are in themselves insufficient guarantee of professional success. The recruit must also learn to weave his way through the labyrinth of the professional culture Every profession entertains a stereotype of the ideal colleague; and, of course, it is always one who is thoroughly adjusted The poorly adjusted colleague is a deviant; he is regarded as "peculiar", "unorthodox", "annoying", and, in extreme cases, a "troublemaker".⁹

And again:

One of the principal functions of the professional schools is to identify and screen individuals who are prospective deviants from the professional culture. That is why the admission of candidates to professional education must be judged on grounds other than, and additional to, their academic qualifications The professional school provides test situations through initial and graduated exposures of the novice By his behaviour . . . the potential deviant soon reveals himself.¹⁰

The professional organization takes over when the newly qualified recruit emerges from the medical school. Part of the point of regulating access to practice is, in fact, that it helps maintain the profession as a band of brothers — a cooperative, egalitarian, mutually supportive fraternity presenting a united front to the outside world. As far as it is able, the organized fraternity will try to enforce this front; but it has to do so in a basically individualistic and competitive market situation. Control over the members is therefore sometimes harsh, expressed in the Caesar's wife standards of the codes of ethics, disciplinary tribunals, and "striking off the register".

But there is more to it than this. In medicine, for example, ideally and to a large extent in practice, there are strong understandings on such matters of "etiquette" as proper conduct, consultation and referral. Doctors should not testify against each other, should not criticize each other in public. At the same time only the colleague-group (other doctors) *who are subject to the same work risks* should have the right to define a mistake and say in a given case whether one has been made: better silence, than admit the right of the layman to intercede.¹¹ There must be no poaching (overt at least) of colleagues' clients and certainly no denigration of another doctor (even, except perhaps by eloquent silence or a gesture, when the patient's interests are at stake). There are, of course, absurdities: such as ponderous discussions in committee as to whether or not listing in the Yellow Pages constitutes

⁹E. Greenwood, "Attributes of a Profession", *Social Work*, Vol. 2, No. 3, 1957, pp. 44-55.

¹⁰*Ibid.*

¹¹Everett Hughes, "Mistakes at Work", *Canadian Journal of Economics and Political Science*, Vol. 17, No. 3, pp. 322-325.

"advertising"¹² and about the permissible size of the brass plate. At the same time "professional misconduct" may include many acts that would never be grounds for censure in other walks of life. For example, the doctor must be very careful how he associates with people in "suspect" occupations such as osteopaths and chiropractors.¹³

Much of the case of the economist opponents of norms of the latter sort rests (as can be seen in footnote 13) on the argument that they are deliberately restrictive economic practices aimed at decreasing the elasticity of demand for medical services: i.e., doctors do not like chiropractors, naturopaths, and so on, because they provide competition for doctors and therefore diminish the volume of their business. The author does not find this very plausible.¹⁴ More telling arguments for "consumer choice" in this matter would seem to be, first, the moral one — that the individual has the right to make up his own mind — and, second, the empirical one — *that he is capable of doing so*. It is precisely this capability that is denied

¹²According to Professor Lees, doctors are allowed to advertise in Switzerland. D. S. Lees, *op. cit.*

¹³On this point, and in view of the current importance of the issue in Ontario, it is perhaps worth quoting from Professor Lees account, *ibid*:

... a doctor in this country (i.e., Britain) may not work with, or even mention the name of, an osteopath. Osteopaths in the United States gained recognition after a long and bitter struggle with organised medicine. In Britain they have not so far succeeded. As the position is not widely known it will be worthwhile to state it briefly. The two major associations are the British Osteopathic Association and the Osteopathic Association of Great Britain. Their members undergo a minimum of four years of training in the principles and practice of osteopathy in osteopathic schools approved by the associations (sic). They maintain and publish a voluntary register of qualified osteopaths, the prime purpose of which is to provide the public with a means of recognising a practitioner of accepted competence. They have the usual 'ethical' regulations, which include a ban on advertising. They made several attempts at state registration in the 1930's, all unsuccessful. We are not competent to judge the medical issues involved, but the case ... illustrates both the conservatism of the medical profession and its collective efforts to suppress substitutes for its own services.

¹⁴Another economic argument turns on the shortage of doctors. Says Professor Milton Friedman (*Capitalism and Freedom*, University of Chicago Press, Chicago, 1962, p. 156), "if the number of physicians is less than it otherwise would be (i.e., because of licensing restrictions) and if they are all fully occupied, as they generally are, this means that there is a smaller total of medical practice by trained physicians ... the alternative is untrained practice by somebody" This is not so at all: the alternative may be to rationalize doctors' practice by providing them with more ancillary help.

A further piece of "liberal" economic argument is Friedman's contention that, insofar as a doctor "harms only his patient, that is simply a question of voluntary contract and exchange between the patient and his physician". In point of fact, "health" is not a commodity of the same kind as real estate or tax avoidance or a haircut or a share quoted on the Toronto Stock Exchange, so that many of the economists' strictures (which may be highly pertinent in respect of professional realtors, accountants, the Institute of Barbers and organized stock-brokers) simply do not apply to the health professions. That is not to say, however, that the protection of the consumer (in this case, the patient) should be left *exclusively to the profession*. But that is another matter to which we shall return.

by the medical profession — not surprisingly, given the principle that the client never knows what is best for himself in matters touching the professional's field of expertise.

Informal Structure of the Profession

It can be argued, however, that these are the mere trimmings of professional social control and that what is really important are the informal workings, the nuances of professional life. These have not been explored in respect to medicine as fully as they ought to be, and such work as we have (for instance, that of Oswald Hall¹⁵) may now be somewhat out of date. In his pioneering work on the medical career and the informal structure of medicine, Professor Hall suggests that it is the function of an inner fraternity of the profession (composed chiefly of specialists, and some general practitioners with access to hospitals and to the "core" specialists) to "organize the provision of medical services": i.e., to control the induction of newcomers and exclude intruders; to allocate positions in the hospital system; to control competition (inside); to enforce rules, reward effort, and distribute patients.¹⁶ In this process "sponsorship" plays a major role, and it is exercised through all the various institutions of the profession and at all stages of the medical career. The members of the inner fraternity (it is suggested) exercise an indirect control over the selection policies of the medical schools by their recommendation of students (and, presumably, by their influence in getting rid of "deviants" — see above). They play a major role in the distribution of internships (the status of the hospital that the young interne gets is very important for his future career). They control the allocation of hospital staff appointments and, for those not on the active staff of the hospital, access to hospital privileges. Through the system of recommendations and referrals, they help to influence the building of the young doctor's practice (it is one of the basic tenets of professional mythology that practice-building should be based on the recommendations of satisfied clients or colleagues). But sponsorship is not nepotism, for (like ancient Chinese bureaucrats) the protégé must live up to the expectations of his sponsor and failure to do so involves not only his own career, *but the prestige of the sponsor himself*.

It is possible, however, that the informal structure of the profession is less monolithic than this account suggests. We shall look at this again in Chapter 7.

¹⁵O. Hall, "The Stages of a Medical Career", *American Journal of Sociology*, Vol. 53, No. 5, 1948. pp. 327-336; and "The Informal Organization of the Medical Profession", *Canadian Journal of Economics and Political Science*, Vol. 12, 1946, pp. 32-33 and 43-44.

¹⁶Nothing is said of medical-political office-holding as a possible additional route to influence in the profession or about the extent to which it may or may not coincide with "the inner fraternity" as defined by Professor Hall. (See Chapter 7.)

Part Two: Medical Organization in Ontario

Introduction

Medical organizations can be categorized in various ways. There are five obvious groupings.

- 1) *"Workplace" organizations, e.g.*
 - the physician's office
 - the group practice
 - the health clinic
 - the hospital
- 2) *Educational institutions, e.g.*
 - the medical school
 - the "scientific" society
 - the specialist associations
- 3) *Mutual interest organizations, e.g.*
 - organizations (such as the Ontario Medical Association) that aim to promote and defend group interests and goals
- 4) *Regulatory organizations, e.g.*
 - bodies "accrediting" other organizations¹
 - bodies registering, licensing and regulating members of the profession
- 5) *Research organizations, e.g.*
 - the medical faculties of the universities
 - research institutes

Some of these "employ" the doctor, others train him, some defend him, and others regulate him or the places where he works. The categories are not, of course, mutually exclusive. The Ontario Medical Association has certain educational functions and at present it plays some part in the process of regulation; the hospital also is a regulatory organization (or at least the medical staff of the hospital is); the university medical school is more than an educational institution, for it employs doctors and conducts research; the College of Family Physicians of Canada is

¹These can be regulatory in intent even though they are voluntary in principle.

primarily an educational body, though its purpose is undoubtedly to further the interests of the general practitioner; the CMA accredits hospitals for junior interne training, though it is primarily a "mutual interest" organization, and so on.

It is partly because of the overlap of functions that the typology will not exactly serve our purpose; and the plan adopted in Part Two follows a modified version of it. There are five chapters. The first deals with the professional associations: the OMA, the CMA, the College of Family Physicians, the specialist associations, the local medical academies, the Federation of Medical Women, and the Association of Medical Students and Internes.² The second chapter introduces the Colleges and other licensing bodies. The third discusses the structure of medical organization in the hospital; the fourth, the medical schools and the Association of Medical Colleges of Canada. The fifth chapter briefly traces the web of inter-relationships among all these bodies, and attempts to identify and elucidate the nature of the Ontario medical elite.

It has been thought inappropriate to burden the text with history, although there are a few historical references in this and in subsequent parts of the report where the narrative seems to require it. The major landmarks in the development of medical organization in the province are set out briefly in an appendix to this report.

²Although the scope of this report is limited to Ontario, it is impossible to discuss medical organization in the province without reference to the CMA, or the Ontario Chapter of the College of Family Physicians without reference to the College as a whole. Indeed, throughout, we shall have occasion to mention many bodies which, being "all-Canadian" (like the Medical Council of Canada and the Royal College of Physicians and Surgeons), have important functions in Ontario.

Chapter 3 The Professional Associations

*Let such as are to inform counsels
out of their particular professions
be first heard before committees.
—Francis Bacon, Of Counsel*

We begin with those professional associations that claim to represent a broad spectrum of the interests of *all* doctors in the province: the Ontario Medical Association and the Canadian Medical Association. We then pass to the associations that represent some of the interests of particular groups of doctors: the general practitioners, represented by the College of Family Physicians; and the various specialist groups, each represented by its own association. Third, there are the associations that notionally represent *all* the interests of *all* doctors in a particular locality: the local medical societies and academies of medicine. Finally, we refer to the representative associations of two “minority groups”: women, represented by the Federation of Medical Women of Canada and its Ontario Chapter; and the Canadian Association of Medical Students and Internes (CAMSI).

This by no means exhausts the full range of professional bodies; there are many to which we can make only passing reference. There are, for example, bodies representing particular group interests such as the Canadian Life Insurance Medical Officers’ Association and the Medical Section of the Canadian Pharmaceutical Manufacturers Association (i.e., physicians employed by drug companies); there is the Canadian Medical Protective Association, a mutual defence organization run by the doctors themselves, the purpose of which is to help members who may be involved in malpractice or negligence suits (it also insures the physician against the costs of defence and damages); and there are a great number of medico-lay societies, which embrace in their membership both doctors and laymen, such as the Canadian Cancer Society, the Canadian Heart Foundation and the Health League of Canada, many with “Ontario” equivalents.

The structure of professional organization is, in fact, tremendously complex, and it is possible here to unravel only the more important strands.

The Ontario Medical Association

The basic objects of the OMA were settled at its first annual meeting, held in Toronto in 1881. These objects were, briefly: to cultivate the science of medicine,

to advance the character and honour of the profession, to raise the standard of medical education, to promote the public health, to further unity and harmony among the members, and to form a connecting link between local medical societies and the Canadian Medical Association. These objectives have not changed,¹ but two important shifts of emphasis have taken place recently in response to changes in Canadian society and the increase in the powers and responsibilities of governments. First, the OMA has become increasingly organized to promote its objectives through overt political action; second, medical economics — the furtherance and protection of the material interests of its members by all lawful means — has assumed overriding importance. These shifts of emphasis are not at all untypical of professional associations in the twentieth century; indeed, they are perfectly natural adjustments to the changing facts of political and economic life. But not all doctors have fully accepted this change. Not to put too fine a point on it, some doctors regard these newer “pressure group” orientations of the OMA as distasteful and essentially unprofessional.²

The primary aim of the Association is to represent the medical profession in Ontario. It now has about 8,000 members, the great majority of whom reside in the province (see below). The figure represents about three-quarters of all doctors in the province. The “non-membership” includes a substantial number of salaried doctors.³ In 1963 only about half the estimated total number of salaried doctors in the province were members of the OMA. The Association has made a determined effort to recruit many more in recent years and the proportion of salaried members is now much greater than half. On the whole, it would seem that a doctor in a large urban area, and in particular Metropolitan Toronto, is somewhat less likely to be a member of the OMA than is his counterpart elsewhere in the province; but this is (in part) because in Toronto he is more likely to be a salaried doctor (for example, a research or academic doctor). It is sometimes suggested that the salaried doctor feels less need of the kind of support that the OMA can give than does the doctor who works on his own.

There is no doubt that the OMA is “representative” of the doctors of Ontario, at least in one important sense. The Association organizes a very high proportion of the total potential, and it includes large numbers of specialists as well as general practitioners. The 1965 membership figures supplied by the OMA to the Committee on the Healing Arts show the following breakdown:

¹Though some have been added.

²Action “to assist in the advancement of medical legislation for the good of the public and the profession” is now one of the objects of the Association provided for in its Charter (Section 5 (8)).

³Salaried doctors include medical scientists and teachers employed in the medical schools, research institutes, and so on; doctors employed by insurance companies and drug firms; public health doctors; and medical administrators.

Ordinary members	4,527
Husband and wife joint members	105
Members over 65	214
Salaried doctors	595
Members resident in other provinces	61
Members in first or second year of practice	430
Internes and postgraduates ⁴	861
Members unable to practise or retired	80
Life, honorary, etc.	641
Total	7,514

A private inquiry by the OMA in 1966 showed the following proportions:

Members in private practice	54.1%
Private practice but seeing only patients referred by other physicians	20.4%
Institutional practice	16.4%
Public health doctors	1.4%
Not in practice (i.e., in administration, in research, retired, etc.)	7.5%

These percentages are of some interest, for they show that while the majority of doctors in Ontario are practising in one way or another, only about half are directly available to the citizen requiring health care.

The governing body of the OMA (under its Charter) is the Council, which is a very large body (over 300 members) elected by the members having voting rights. It consists of delegates elected from territorial divisions (essentially, local branch societies), of which there are at present sixty-one; certain members of the Board of Directors (see below) who are elected by district associations, of which there are at present eleven; and the chairmen and secretaries of the district associations. The Council has the formal powers of a meeting of all the members (though these can be revoked by a special meeting of the members). Any member is permitted to attend Council meetings and (with the permission of the Chairman) to participate in the discussion; but he cannot vote. The Council is frequently referred to by the OMA as the "Parliament" of the Association, and that is essentially what it is: an elected assembly which has power (which it seldom uses) to initiate policy but which does ratify, amend, reject, and refer back. Since you cannot, as Lloyd George once observed, conduct business through a Sanhedrin, the affairs of the Association are administered by a twenty-four member Board of Directors. Eighteen of these are elected by the district associations (which are really groupings of local medical societies for electoral purposes), five are elected by Council, and one is appointed by and from each of the medical schools in the province in turn to represent the medical schools' collective interests. Directors serve for one-year terms except the medical schools' director who serves for two.

⁴Internes and members starting in practice have certain fee privileges.

Between meetings of the Board of Directors the affairs of the Association are attended to by an Executive Committee consisting of the officers: the President, Vice-President, Honorary Treasurer, immediate Past President and the Chairman of the Board of Directors. The Presidency is a prestigious office; but, like all such offices, its *effectiveness* depends in large measure on what the particular incumbent makes of it. In the hands of a forceful and articulate person it can be a major influence within and outside the Association, though he has only a year in which to make that influence felt. The President represents the Association in all its dealings with outside bodies, including governments, and he takes the chair at all Executive Committee meetings.

On paper, the Council of the OMA is the key policy-forming body: the Board of Directors, the Executive Committee and the Secretariat are there to carry out its wishes and provide continuity between meetings. For many reasons, however, the Council no longer occupies the pre-eminent position the constitution would suggest. It is very large, and although mid-winter meetings have become more or less routine over the past few years, it can meet only infrequently (not more than two or three times a year). The great range of the OMA's activities now requires much more time and attention than the Council can give. In its 1965 Report to Council, the Board of Directors said:

Due to the ever-accelerating pace of modern living, the Board of Directors is placed in the position of dealing conclusively (sic) with matters which would at one time have come to Council for decision The number of problems that confront us is staggering and this necessitates conservation of Council's time so that it may deliberate and make decisions with respect to the more important questions of policy Reports to the Annual Meeting of Council serve the purpose of a quick march past of Association activity at the level of Board, Committees, and Sections (Author: for an explanation of these, see below).

The twenty pages of the Directors' report to Council in May 1966 were a compression of some 500 pages of Board Minutes and 250 pages of Executive Committee minutes. Most of the briefs prepared by the OMA for policy purposes originate in committee and then go to the Board of Directors for decision. There is, we were told, "rarely time for them to be approved by Council". This is of some significance since once a policy has been presented publicly as OMA policy it is almost inconceivable that Council will repudiate it. There is, however, clear evidence that Council does on occasion reverse or refer back Committee recommendations on controversial subjects; and it is clear, also, that decisions would never be made on the highest "economic" (i.e., political) issues, such as the principles of the tariff or medical insurance, without some general debate in the Association at the Annual Council Meeting.

The Association has an elaborate network of committees. As most of them are referred to again later in the report, it is unnecessary to go into detail at this

point. The two most important committees today, substantively, are the Committee on Economics and Medical Practice, the principal "medical economics" policy-making body; and the Committee on Tariff, which handles the details of the Schedule of Fees and fee-review questions. The top leadership tends to be well represented on both of these. Among the many important health policy committees there should be mentioned those on Child Welfare, Hospitals, Maternal Welfare, Medical Aspects of Traffic Accidents, Education, Pharmacy and Public Health. There is also a Committee on Operating Room Deaths which collects and collates material on cases of death under, or resulting from, anaesthesia, cases of cardiac arrest and the like. The other standing committees tend to fall into two groups: those that handle matters of internal administration (such as By-Laws, Insurance and Membership), and those that cover matters relating specifically to the status and rewards of the profession (such as Ethics, Public Relations, Mediation). Important special (or ad hoc) committees are appointed when the need arises. For example, in recent years, there have been committees on changes in the Public Hospitals Act, on Therapeutic Abortion, to consider the Report of the Hall Commission; and several special committees on tariff, on nursing procedures, and on clinical services performed by hospital residents and internes. At the time of writing, a high level Action Committee was planning the Association's strategy on medicare.

A further important aspect of the structure of the OMA is the Section. Any group of members of the Association who are primarily concerned in a particular aspect of medicine may be recognized as a Section of the Association on making formal application. The existing Sections are organized in some cases by mode of practice, in others by specialty. Thus there are Sections on Coroners, General Practice, Group Practice, and Salaried Physicians; and there are Sections on Allergy, Anaesthesia, Clinical Pathology, Geriatrics, Haematology, Industrial Medicine, Internal Medicine, Ophthalmology, Orthopaedic Surgery, Physical Medicine and Rehabilitation, Plastic Surgery, Psychiatry, Radiology, and General Surgery. Some (judging by the Annual Reports to Council) appear to be relatively inactive, others quite vigorous. Most are concerned with fees and most have a Section Tariff Subcommittee which meets with the main Tariff Committee. In 1966 almost all Sections reported activities relating to the tariff; about two-thirds reported activities relating to scientific matters — for example, the holding of scientific meetings and the presentation of papers. The Sections also prepare briefs on policy matters affecting their interests, and these are submitted to the Board of Directors for approval. Section representatives cannot vote at Council Meetings, but they may sit in (as may any OMA member) and they may participate in discussion at the invitation of the Chairman. Any recommendation for action from a Section is made to the Board of Directors, and whenever the Board is considering a matter of particular interest to a Section it invites representatives from that Section to attend and take part in the discussion.

It is sometimes said that the OMA is dominated by its specialist members. It is hard to give precision to this suggestion because the facts are subject to a variety of interpretations. Between 1954 and 1964, eighty-one doctors were directors of the OMA; of these, thirty-six were general practitioners and forty-five were specialists. In 1963 the ratio of specialists to general practitioners on the Board of Directors was 1.4 to 1, whereas the ratio of specialists to general practitioners in the total doctor population in the province was only 0.7 to 1. In this sense, the general practitioner was underrepresented in the higher councils of the OMA. Yet, of the thirty-six general practitioners who served on the Board in this period, ten came from communities of 5,000 population or less, and eight came from the large metropolitan areas (mainly Greater Toronto). Since general practitioners constituted 19 per cent of the total doctor population in the small communities and 33 per cent of the total doctor population in the large metropolitan areas, general practitioners from very small communities were overrepresented on the Board while those from metropolitan areas were greatly underrepresented. At the same time, specialists from the small and medium-sized towns appeared to dominate the Board out of proportion to their distribution in the specialist population of the province as a whole. Of the forty-five specialists serving on the Board in this period, twenty-two were from towns and cities of from 10,000 to 100,000 population, yet only a third of the specialist population was in those centres. In sum, the specialists were overrepresented in proportion to their numbers in the doctor population as a whole, but they came from the small and medium-sized towns and cities rather than from the large metropolitan areas.⁵

This distribution undoubtedly reflects the manner in which the Board of Directors is constituted (as we have seen, it is for the most part elected on a kind of electoral college basis to represent large geographic areas); and it might further be argued that it was never the intention of the OMA to provide for a nice constitutional balance between specialties and general practice on its governing bodies.

In 1967-1968 four of the five members of the OMA Executive Committee were specialists; fourteen of the twenty-four members of the Board of Directors were specialists. A sample check on Council members for 1963 and 1966 indicated an almost equal division between general practitioners and specialists in both years. Between 1954 and 1964, 131 doctors filled the available committee positions. There was a fairly proportionate geographic representation. Of these 131 doctors, sixty-seven were University of Toronto graduates, thirty-nine were graduates of the three other Ontario medical schools at that time, fourteen came from other Canadian schools and eleven were immigrant doctors from Britain. University of Toronto "dominance", once much criticized, now seems to be declining (as one might expect) as also, it appears, is the British emigrant element in the leadership.

In any professional association the size of the OMA (and particularly one which claims to represent an entire profession within the province) there are bound

⁵These figures are taken (by permission) from an unpublished M.A. dissertation by Professor Kathleen Herman, Department of Sociology, Queen's University.

to be significant differences of interest impinging on the policy-making process and on the internal workings of the organization. In some aspects of its organization and work the specialist-general practitioner division will be significant (for example, in the Tariff Committee); in others, the urban-rural, and particularly the metropolitan-non metropolitan, division will come to the fore; in others again (for instance, on the question of direct-patient-billing under medical insurance schemes), the sociological nature of the locality and of the patient population may override other considerations.⁶ It was, indeed, represented to us by a leading OMA office-holder that differences of ideology (or of "philosophy", as the medical profession prefers to call it) are generated much less by "type-of-doctor" divisions than by "type-of-locality" divisions. In this matter, the local medical society (see below) may assume a major role as an articulator of differences in local attitudes and opinion which it will not be easy for the OMA leadership to either control or ignore. (Local medical societies are usually "branches of" the OMA, but not all of their members are necessarily OMA members and the society has at least some autonomy.) Two closely related type-of-doctor divisions, however, seem to be of major importance. One is that between medical school and research doctors (or "ivory-tower theorists") and the rest, about which more will be said later; the other is that between the salaried as a whole (who include, of course, "academic" doctors) and the non-salaried. The number of salaried doctors is increasing, and there is little doubt that this is regarded in some quarters as a profound threat to the "doctor-patient relationship" which (though exceedingly vague) remains one of the fundamental articles of the OMA faith. In this connection it is worth remarking that in 1963 a resolution was brought to the OMA Council to the effect that "no member of the Board of Directors (of the OMA) shall be a full-time employee of any outside organization".⁷ This resolution was, understandably, defeated; but the interesting thing is that it was raised at all.

It would be wrong to leave the impression that the OMA is an organization continuously riven by internal feuds. We found no evidence to suggest that there is widespread dissatisfaction with the organization among the rank and file. On the contrary, the great majority of doctors we talked to supported it. Local pockets of resistance do, however, arise from time to time on particular issues when a group of local doctors will be found defying the OMA. Undoubtedly there are often many "interests" to be reconciled. But as in any large organization, the majority are content to pay their fees, get on with their work, and leave it to others to clarify and represent their interests;⁸ and the OMA leadership is as continuously

⁶For example, where the majority of the local doctors' patients are company employees, or PSI- or OMSIP-insured, there may be little point in taking a stand on direct billing; but this may be an important issue for doctors in another type of locality.

⁷The author is indebted to Professor Herman for drawing his attention to this event.

⁸One of the interesting phenomena of voluntary association in the West in the present century is the rise of private "statesmen" and "bureaucrats" whose (sometimes almost full-time) job is to represent the interests of their fellows in negotiation and bargaining with other groups and with governments.

worried about the "apathy" of its members as is the leadership of any comparable body. The following extracts, taken at random from the *Ontario Medical Review*, will give a flavour of the situation.

In the past fourteen months we have asked some seventy chiefs and presidents of hospital medical staffs the question: "Is the OMA a meaningful organization to you?" Sometimes the silence is embarrassing. It is a question that many of our members must ask themselves when they are writing the cheque for their annual fees. It is a question that is answered for every member when he receives his "Reports to Council" Have you tried making your Association more meaningful by joining with (your confreres) in discussion and debate?⁹

We were recently intrigued by the statement of a Branch Society representative at a District Executive meeting: "Our Branch Society is a little doubtful about the OMA; we don't trust the Secretariat" — followed by hasty and polite apologies: "We don't mean you!" (This was reassuring and narrowed it down to the other four members of the Secretariat.)¹⁰

I often feel sorry for those you elect to make decisions. They consider matters in the light of what is sound for the public and the profession in the years ahead. These decisions are not always popular because individual doctors tend to look at them from the point of view of their personal and immediate situation. A good example is the advice given to deal directly with patients. There is no question in the mind of the Council and the Board of Directors that this is sound advice. *That the majority of members have chosen not to take it does not, in my view, destroy in any way the validity of the policy.* In this instance, time will be on the side of the Council and Board.¹¹

The mood of the audiences last year was quieter than usual—hardly anybody shouting . . . OMSIP really hasn't generated enough indignation yet

There are enough doctors in Ontario now that it is difficult for a great many members to know personally those being nominated for office. Actually the job of the Nominating Committee is just as often to find somebody who will take the nomination, rather than the best man for it.¹²

As in many organizations, it appears that the OMA leadership is much more concerned with the downward flow of communication than with the flow the other way. (One pertinent comment is that the Association leadership is continuously worried about the need for "mouthpieces" at branch levels but shows little sign of recognizing its own need for "hearing aids".) It is interesting to reflect how far this situation (which, it should be stressed, is by no means unique) is due to

⁹Secretarial Soliloquies, *Ontario Medical Review*, May 1965, p. 362.

¹⁰Secretarial Soliloquies, *Ontario Medical Review*, April 1966, pp. 300-301.

¹¹Dr. Glenn Sawyer, General Secretary of the OMA, "What Does the OMA Mean to Me?", *Ontario Medical Review*, December 1966, p. 863. Emphasis added.

¹²Secretarial Soliloquies, *Ontario Medical Review*, February 1967, p. 111.

a lack of understanding of the realities of the communications process in large organizations and how far it is consciously oriented towards controlling the membership.

It should perhaps be added that various "fringe benefits" are provided to attract and hold the membership: life, office overhead and disability insurance; some legal advice; a placement service; and a benefit fund to relieve hardship due to sickness, accident, death or other calamity.

The varied activities of the OMA are more fully covered elsewhere in this report. In an attempt to get a general overview, we scrutinized the Association's journal, the *Ontario Medical Review*, and did a rough content analysis for the years 1961 through 1963 and the first half of 1967. All the material appearing in editorials, main articles and the feature called "Secretarial Soliloquies" was classified under twelve heads. Not included in the count were reports from OHSC and PSI, and the monthly articles listing new drugs and discussing legal and business affairs for doctors. It was felt that the feature articles, editorials and "soliloquies" would be most likely to reflect the current interests and policy positions of the organization. The categories used were as follows:

- 1) OMA internal administration, including reports of meetings, elections, etc.
- 2) Public relations: reports on liaison activities and external activities affecting the interests of the OMA.
- 3) Medical insurance, private and public schemes.
- 4) Organization of the medical services, including hospital organization, group practice, manpower needs, ambulance service, etc.
- 5) Medical education.
- 6) Technical medical papers, including clinical studies and medical statistics.
- 7) Technical, but non-medical, papers: for example, papers on medical and health services administration.
- 8) Medical history.
- 9) Relations with other professions.
- 10) Tariffs, fees, etc.
- 11) Professional standards, ethics.
- 12) General interest material: for example, foreign medical information, articles on the doctor in society, etc.

The results are presented in Table 1.

TABLE 1
Content Analysis of the Ontario Medical Review
1961-1963 and first half of 1967

Year	OMA Admin.	OMA Public Relations	Medical Insurance	Medical Serv. Organizations	Medical Education	Technical Medical Papers	Technical Non-Med. Papers	Medical History	Relations with Other Professions	Tariffs, Fees	Professional Standards	General Interest Reports	TOTAL
1961	36	14	8	10	7	12	10	1	3	4	3	4	112
1962	40	13	11	9	1	16	7	—	7	1	2	—	107
1963	32	17	22	7	3	8	15	8	5	1	4	—	122
1967 (to the end of July)	19	6	2	3	1	9	8	12	6	2	2	3	73
TOTAL	127	50	43	29	12	45	40	21	21	8	11	7	414

Evidently the *Review* is essentially a house journal: a means of communication with the rank and file. Only about 10 to 15 per cent of the space is devoted to scientific and technical papers (for which the *Canadian Medical Association Journal* is the main source); and relatively little attention is devoted to medical education. The subjects "relations with other professions", "professional standards" and the tariff are perhaps considered too delicate for public debate. It would appear that very little that is critical of OMA policy is published.¹³ The prominence given to medical history is somewhat fortuitous: this is largely accounted for by the appearance, as a long series of articles, of a history of the OMA prepared by Dr. Routley, a former Secretary.¹⁴

We may summarize at this point by saying that, in the realm of policy formulation, the principle of "democratic centralism" is well supported in the OMA. Policy proposals usually emanate from the top, but although the relative brevity of the annual meeting of Council ("a brisk march past of the year's activities" is the popular headquarters phrase) would seem to foster oligarchic control, we found little evidence of sustained resentment, even from some rather outspoken critics of "the medical establishment" that we encountered. The degree to which delegates from the local branches are literally "delegates", carrying the agreed views of the membership, or "representatives", using their own judgement, varies from one local society to another. In some of the smaller ones, representation appears to be almost on an ad hoc basis.

An equal number of delegates and alternates are elected at an annual plenary meeting and, shortly before the OMA Council meetings take place, enough of these to make up the society's quota are hastily pressed into service. At the other extreme, there are societies like the Hamilton Academy of Medicine, which (we were told) actually holds briefing sessions for its delegates before each Council meeting. But every respondent we talked to thought that OMA policy did represent, in general, a consensus of medical opinion; though several asserted that the OMA leadership tended to take the initiative in suggesting what it should be.

Some resentment arises over decisions taken between meetings, when the office-holders exercise a great deal of discretionary authority. A good example of this was the decision (taken, we were told, entirely at headquarters level) to participate in Mediscope, a public relations operation presented at schools in the province. This enterprise, though successful, cost a great deal of money and necessitated an increase in fees. The doctor, like everyone else, is easily hit in his pocket, but the dispute that followed illustrates also an important facet of the

¹³It publishes very few letters from members, for example, and those it does are usually laudatory.

¹⁴Dr. T. C. Routley was in practice in Toronto when, in 1918, he was called to become the part-time Secretary of the OMA. In 1923 he was appointed General Secretary of the CMA, becoming the first full-time executive of organized medicine in Canada, a post he held for more than thirty years. Between 1923 and 1938 he held the secretaryship of both organizations.

physician's mind: he is highly individualistic and has a deep distrust of bureaucratic administration in all its forms. It is ironic that in order to protect his interests he must subject himself increasingly to it.

The Canadian Medical Association

The Ontario Medical Association is an independent, autonomous body, incorporated under the laws of Ontario. Yet it is also a "Division" of the Canadian Medical Association, as are all the provincial medical associations in Canada. Membership is virtually conjoint. There are some members of the OMA who are not members of the CMA, but the proportion is quite small. The OMA collects a combined fee and passes a percentage to the CMA. This situation has some rather odd implications. For example, the OMA is older than the CMA as presently constituted;¹⁵ some of the Divisions of the CMA are also the licensing bodies in their provinces,¹⁶ which the OMA is not; and the membership of the OMA constitutes nearly half the total membership of the CMA. To put the last point more bluntly, the OMA is perhaps big and powerful enough to get along without the CMA; it is doubtful whether the reverse is true. The By-Laws of the OMA make it clear that as long as the OMA "continues as the affiliated medical body of the CMA, the name 'Canadian Medical Association—Ontario Division' may be used to refer to the association, *although the correct and proper name of the association to be used in all its official dealings shall be and remain the 'Ontario Medical Association'.*"¹⁷

The CMA is thus a federal-type association, with considerable autonomy residing in the provincial Divisions; and its membership is largely controlled by them, since (with minor exceptions, such as the CMA's "members-at-large"¹⁸) they are the effective recruiting agencies. Furthermore, "a physician who becomes unacceptable as a member of the Division in which he resides may not continue to be enrolled as a member of the Canadian Medical Association".¹⁹

In addition, the CMA has affiliated with it a large number of medical and medico-law societies: specialist societies such as the Canadian Anaesthetists' Society, the Canadian Association of Pathologists and the Canadian Dermatological Association; the life assurance physicians and drug company doctors; the College of Family Physicians and the Royal College of Physicians and Surgeons of Canada. The strictly medical bodies are *entitled* to a seat on Council; but the by-laws make it

¹⁵The OMA was founded in 1881; the CMA, *in its present form*, dates only from 1909.

¹⁶These include, for example, the provincial medical associations in Saskatchewan, Prince Edward Island, New Brunswick and Alberta. The Royal Commission on Health Services (the Hall Commission) recommended against this practice (of combining the licensing and representational functions in one body) but little has been done to implement the recommendation.

¹⁷Emphasis added.

¹⁸And, we were informed, the CMA will not even admit a "member-at-large" without first obtaining the permission of the appropriate Divisional Association.

¹⁹CMA By-Laws Chapter VI, Sec. 2(b).

plain that affiliation implies no commitment by either party to the policies of the other. The medico-lay societies (Canadian Cancer Society, Canadian Heart Foundation, and so on) *may* be given a seat on Council. This applies also to other "mixed" affiliated bodies, such as the Canadian Council on Hospital Accreditation, and to non-medical associations that are affiliated, such as the Canadian Nursing Association. Two representatives of CAMSI are "invited to attend" sessions of the CMA Council.

The governing body of the CMA is its General Council, which is large but not so large as the Council of the OMA (approximately 180 members compared to about 300). It seats representatives from the ten provincial Divisions in proportion to the size of their membership. Each Division elects its own representatives including a number specifically named to serve on each of the important Nominating and Executive Committees of the CMA. The other members of Council include (aside from representatives of affiliated societies just mentioned): the various office-holders, the chairmen of committees, past presidents, past chairmen of Council; the Presidents and Secretaries of each of the provincial Divisions; the Deputy Minister of National Health and Welfare; the Director-General of Treatment Services of the Department of Veterans' Affairs; the Surgeon-General, Canadian Forces Medical Service; and a dean of one of the medical schools representing the Association of Medical Colleges of Canada.

The Executive Committee, which represents the General Council in all its affairs between meetings of the Council, consists of the officers of the Association *ex officio*, the elected divisional representatives,²⁰ and officials such as the General Secretary and the Assistant Secretaries. It meets at least once a quarter.

The officers are the President, the President-Elect, the Past President, the Chairman of the General Council and the Executive Committee and the Honorary Treasurer. The secretariat consists of a General Secretary, a Deputy General Secretary, a Secretary for Medical Economics and a Secretary for Public Relations. There is also an editorial staff for the official *Canadian Medical Association Journal*, which began publication in 1911 and has been published as a weekly since 1960; and for the *Canadian Journal of Surgery*, which the CMA publishes quarterly. The total staff of the Association numbers about sixty.

Since Divisional Associations elect members to Council in proportion to the size of their membership and the OMA is entitled to three representatives (members of its own Executive) on the Executive Committee (compared to two from Quebec and one each from each of the other provinces), the OMA is well represented in the higher councils of the Association.

There is a liaison committee with "the French doctors", L'Association des Médecins de Langue Française du Canada, which has its headquarters in Montreal;

²⁰The CMA "recommends" that the representatives of the Divisions on its Executive Committee should be members of the Divisional executive (i.e., in Ontario, members of the OMA Executive Committee) "in order that liaison and communication be facilitated".

and there are "provincial committees" for the French doctors in Nova Scotia, New Brunswick, Quebec, Ontario and the Western Provinces.

The Association operates the Canadian Medical Retirement Savings Plan and new medical and related institutions: the Medical Council of Canada in 1912; the Canadian Hospital Association (originally established within the CMA as its Department of Hospital Service in 1927); the Royal College of Physicians and Surgeons of Canada in 1929; the Canadian Cancer Society in 1937; Trans-Canada Medical Plans (a kind of coordinating body for prepaid medical care across Canada) in 1951; and, most recently, the College of General Practice (now College of Family Physicians) in 1954.

The Association operates the Canadian Medical Retirement Savings Plan and the Canadian Medical Equity Fund. The first of these was set up in 1957 to take advantage of an Income Tax amendment allowing self-employed doctors to invest tax-deferred funds for retirement. The latter is similar in many ways to the retirement savings plan except that there is no eligibility for deferment of income tax, but the doctor is free to liquidate his holdings if he wishes.

The operation of the CMA can be fully understood only in the light of two facts: that health is a provincial matter, though federal assistance is considerable and often far-reaching; and that the CMA is itself a federal structure which must act cautiously and, in form at least, with the step-by-step consent of the Divisions. Its relationship with the provincial medical associations has emerged slowly and reflects, even now, a tension between concern over the consequences of fragmentation in the medical profession and a desire to adhere scrupulously to a constitutional division of functions. A national policy for organized medicine in Canada, insofar as it is possible at all, can emerge only through the existing interlocking network of provincial and national committees.²¹

The most important policy committees of the CMA are described below. The Committee on Medical Economics is backed by the resources of the Association's Department of Medical Economics, the primary purpose of which is to give continuous study to the question of insurance plans and prepayment for medical services. It has the services of a full-time economist and gathers detailed economic, legal and administrative material on medical insurance problems in Canada and abroad. The Department has recently carried out an important survey of the distribution of medical manpower in Canada, the results of which were still being processed at the time of writing (though some preliminary findings had been published). Whereas the provincial associations are chiefly concerned with their own tariffs and with provincial "economic" matters, the CMA attempts to operate on a broader base. We were told that the Department gets many requests for

²¹The usual structure of a standing committee of the CMA is as follows: a chairman appointed by the Executive Committee, a local nucleus chosen by the chairman (i.e., from those most readily and geographically available to him) and members nominated by the Divisions.

assistance on medical economic questions from the smaller provincial associations; the OMA, however, clearly relies mainly on its own resources.

There is a series of policy committees, some of which overlap with, and some of which are complementary to, the concerns of OMA committees: a Committee on Aging, a Committee on Child Health, a Committee on Occupational Medicine, a Committee on Maternal Welfare, a Committee on Nutrition, a Committee on Pharmacy, a Committee on Public Health, a Committee on Physical Education and Recreation, a Committee on Rehabilitation, a Committee on Medical Education and a Committee on the Medical Aspects of Traffic Accidents.

The various accrediting functions of the CMA also are backed by appropriate committees. There is a Committee on Approval of Intern Training, a Committee on Approval of Schools for Laboratory Technologists and a Committee on Approval of Schools for Radiological Technicians. The Committee on Rehabilitation takes a hand in organizing the training programs for physical and occupational therapists. The Committee on Hospital Service and Accreditation develops and represents the interests of the CMA vis-à-vis the Canadian Council on Hospital Accreditation.

Lastly (aside from the usual "housekeeping" committees such as Archives, By-Laws, Awards and Scholarships, Scientific Program, and so on) there are the committees that relate to the "image" of the profession and its regulation: the Committee on Public Relations (which is backed by a separate Public Relations Department), the Committee on Ethics (see below), the Committee on Income Tax (which "studies the implications of legislation and rulings relating to income tax insofar as they affect the interests of the medical profession") and the Advisory Committee to the Federal Government, a valuable liaison committee to which reference is made again later.

The annual general meeting is itself an event of some importance, since it provides a rare opportunity for doctors from across the continent to come together to discuss matters of mutual interest — and sometimes mutual discord. The Scientific Program, which is frequently addressed by leading world medical authorities, is a major part of this occasion.

This brief account by no means exhausts the range of the CMA's activities. Its conduct of relations with the federal government is of increasing significance. In addition to the work of its Standing Committees, the CMA frequently sets up ad hoc special committees to advise on a wide variety of problems. In recent years, for example, there have been committees on Prepaid Medical Care, on Policy (relating to "the gradual encroachment by government on the practice of medicine"), on Medical Services in Australia, on Group Practice, on the Care of Narcotic Addicts, on Professional Self-Discipline and on Hypnosis. These committees recommend action by the CMA and often also make submissions to government departments, to committees of the federal Parliament and to other professional bodies.

The College of Family Physicians of Canada, Ontario Chapter

The College of General Practice of Canada was established in the summer of 1954, with the assistance of the Canadian Medical Association, by a group of doctors who were concerned about the declining status of the general practitioner. Its name was changed to College of Family Physicians of Canada at the annual meeting in Vancouver in July 1967. Not least among the reasons for this change of name was the growing feeling that there now exists a body of knowledge and skills that can properly be called "family care" and which may even be entitled to claim status as a specialized branch of medicine. The prime object of the College is to raise the standard of family practice, and to encourage and maintain recruitment to the ranks of the family doctor. Thus its purpose is basically educational. But since the leadership shares a concern about the decline in the status of the family doctor, it is inevitably pushed beyond this and is increasingly under pressure to become a spokesman for the special interests of the general practitioner everywhere.

Here is an organization which, slowly but inevitably gathering strength, will become the voice of general practitioners throughout the country, in the councils of the many medical organizations to which we and our colleagues belong; to the hospital boards; to medical schools, the universities, and to our patients.²²

The College headquarters is in Toronto, and there is a chapter in each province. The headquarters of the Ontario Chapter (founded in 1954) also is located in Toronto, at present in the private office of the doctor who acts as part-time Executive Secretary of the Chapter. He receives a small stipend. Membership in the College is dependent on "continuing postgraduate study" (to be defined later)²³ by the practising physician. Applicants for Active Membership in the College must be members of the CMA or of the French-speaking medical association in Quebec, and they must have had five years in general practice or its equivalent before seeking membership (or four years if they have had two years of interne training). Doctors who do not meet this requirement may apply for Associate status.

The College is the only professional medical association in Ontario that demands a continuing educational program as a condition of membership (in brief, a requirement of 100 hours of study every two years). Unlike some professional organizations, the College is remarkably frank about the reasons for its failure to recruit and retain members. Roughly a quarter of all the general practitioners in the country belong, but in spite of real and sustained efforts on the part of College activists it does not seem possible to get the figure much above this level, and the annual dropout rate is of the order of 20 per cent. Some of this is due to

²²Dr. F. Murray Fraser, President of the College 1960-1961. Sixth Anniversary Address.

²³See p. 238. Ann Cartwright's study of doctors in the British National Health Service (*op. cit.*) found that doctors active in postgraduate courses enjoy being general practitioners, are less obsessed with prestige, and complain less about "trivial" demands by patients. Which is cause and which effect is, of course, another matter.

the usual factors: non-payment of fees, retirement and death — but much is attributable to failure or reluctance to comply with the educational requirements²⁴ and to movement from general practice to a field of specialization or to another type of medical employment.²⁵ Some hospitals now *require* membership in the College for admission to their Departments of General Practice. A doctor certificated in a specialty may be admitted to active membership in the College provided he does considerable general practice and has “a genuine interest in its welfare”. This is, no doubt, more important in some of the smaller provinces where there is a high proportion of doctors of this kind, particularly general practitioner-surgeons. (The College’s first President was a general practitioner-surgeon, though he came from Quebec.)

The College (which is chartered under Federal Law) is governed by a Board of Directors composed of the National Executive Committee and one Director from each province (except Quebec and Ontario which have two each) elected by the provincial chapters. The Board elects its own Chairman annually. It meets normally twice a year, and between meetings the Executive Committee has full powers to act, subject to subsequent ratification by the Board. The Executive Committee consists of the President, immediate Past President, President-Elect, Honorary Treasurer, Chairman of the Board of Directors and (a recent innovation) one Member-At-Large appointed by the Board of Directors. As there is no Council, the “Parliament” of the College is the annual general meeting itself. There is a full-time Executive Director, who is responsible to the Board, and an Editor of the College journal, recently renamed *The Canadian Family Physician*, who also acts as Assistant to the Executive Director.

The Ontario Chapter of the College had a membership in 1967 of 1,162, or roughly half the national membership of the College and about 28 per cent of all the family doctors in Ontario. Like the other provincial chapters it is governed by a Board of Representatives which normally meets twice a year and consists of the Provincial Chapter Executive Committee, plus one representative from each Regional Chapter within Ontario (of which there are at present ten), the chairmen of standing committees (or their alternates), and any member of the National Executive of the College who happens to live in the province. The Executive Committee acts (subject to ratification) between meetings of the Board and is composed of the President (elected annually), the President-Elect, immediate Past President, Honorary Treasurer, Chairman of the Board and the Ontario Chapter’s two representatives on the National Board of Directors. There is a part-time, paid Executive Secretary.

²⁴The Associate Member must comply with the 100 hours rule, but there are categories of Active (Exempt) and Inactive Member for the elderly and for those temporarily unable to practise.

²⁵Doctors moving out of general practice may become Sustaining Members. There are no study requirements for them, but they cannot vote or hold office.

Thus there is real and effective cross-membership between the National body and Provincial Chapter at the administrative and policy-making levels; and the provincial chapter committees, too, very closely follow the national pattern. Among the principal Ontario Chapter committees are those on credentials (this committee considers applications for membership, and fixes and assesses the member's study program on which his continuance in membership is based²⁶), on membership (which deals with recruitment), on hospitals, on education, on research, and on public policy. The work of the committees on hospitals, education and research will be considered again later; but a few comments on some of the other committees may not be out of place here.

The Public Policy Committee handles public relations for the Chapter, but it appears to operate within fairly close guidelines laid down by the corresponding national committee. It is College policy to keep out of medical politics, but anything else that affects the G.P. is considered. It did not appear to us, however, that this Chapter Committee was particularly aggressive or active at the present time. Perhaps this is not a matter for independent provincial action. The Membership Committee, on the other hand, has been very active of late, when (following a national membership workshop in New York in 1966) a province-wide drive was initiated, during the course of which attempts were made to reach every general practitioner in the province, in person if possible or otherwise by letter. One doctor in Kemptville (who was appointed an "area captain" for this purpose) told us that during this time he or his committee personally saw every doctor in the area. There is an active Mental Health Committee which holds seminars on mental health for G.P.'s in various parts of the province, and one doctor on this committee (who is also a member of the CMA Committee on Mental Health) has a grant from the federal government for research into psychiatry and family medicine.

The precise relationship between the Ontario Chapter and the National body is not clear. It appears that the officers of the Chapter at least have a measure of autonomy, but the work of committees seems often to be circumscribed by national committee directives. For example, a brochure on setting up Departments of General Practice in hospitals prepared by the national hospital committee sets the guidelines for the local (i.e., provincial) hospital committees: there is also a national brochure on training in family medicine for the guidance of the local graduate education committees; the central credentials committee reviews all applications for membership or for study credits forwarded by the local credentials committee; and even the recent membership drive was guided by directives from a national membership workshop.

The Ontario Chapter regional chapter committee has worked hard to set up new regional chapters within the province, and (as was mentioned above) there are now ten of these. (A Chapter can be formed when six or more doctors residing

²⁶After provincial assessment the member's case goes to the national credentials committee for approval.

in the locality petition the Provincial Chapter.) All were more or less dormant until recently, but in the past two or three years there have been signs of increasing activity as more young men have come forward. The Toronto Chapter, which has about 400 members, is the largest and most active, organizing clinical days in the hospitals and an annual scientific convention. Members of the Hamilton Chapter have been active in planning the family medicine program at McMaster University to which reference is made later (p. 230); the instructors in the program and some of the family doctors on the scheme's advisory committee are members of the Chapter. However, the general feeling seems to be that the Hamilton Chapter is somewhat overshadowed by the local Academy of Medicine (see p. 50). The Kingston Chapter has a strong centre in Kingston itself, two-thirds of the Kingston G.P.'s being members; but the surrounding areas are weakly represented. A real spirit of solidarity has developed in Kingston as a result of the dispute with the University and Medical School over bed privileges in Kingston General Hospital. Not surprisingly, much depends on the interest and concern of a few activists. The Waterloo Chapter which has about a quarter of the local doctors in membership, provided the President of the Ontario Chapter of the College in 1966-1967. The Dundas County Chapter, which includes three out of four family doctors in Kemptville and half of those in Brockville, and whose membership has recently increased by 10 per cent, had as its president in 1966-1967 a doctor who is a charter member of the College and who was an area captain in the recent membership drive. The Secretary of the Grey-Bruce Chapter, an active branch with about 30 per cent of the local G.P.'s currently in membership, is Chairman of the Ontario Chapter Membership Committee.

Fundamentally, says the College's official brochure, "the College is charged with accomplishing for the general practitioner through education what the Royal College of Physicians and Surgeons of Canada is accomplishing (for specialists)". Behind this stated aim, however, there lies a good deal of controversy, which we shall have to discuss. One point must be noted here in that connection, and that is that the College, unlike the Royal College, is not an examining body — nor is there yet any consensus as to what might constitute a sufficient body of specialist knowledge in "family practice" which could be examined. The College is undoubtedly right, however, in two of its most basic beliefs. These are that general (or family) practice is an important entity in itself, and not merely the absence of a specialty; and that a general physician can no longer be satisfied with the minimal amount of education and training that he receives before being granted a licence to practise. The College is doing excellent work, often in the face of considerable and not always wholly scrupulous opposition from other medical interests, in attempting to define, and refine, the content of modern family practice; in stimulating the interest of practitioners in further education and training; and in advancing the standards of the group. We shall look at its accomplishments in more detail later.

The College publishes its own journal, carrying scientific articles of interest to general practitioners and "other information of value to those wishing to continue postgraduate studies".

As a pressure group the College is much concerned to have family practice more firmly established as part of the medical school's curriculum, to get family practice teaching units established in the teaching hospitals, and to preserve and extend the rights of the general practitioner in community hospitals where his presence is increasingly threatened. The College officially eschews "medical economics", believing that such matters are incompatible with its basic educational purpose. This has led to some grumbling from sections of the general practice community who feel that the College has not been sufficiently aggressive in defence of their interests and that it would be more attractive to the average practitioner if it were.

We have already noted the OMA Section on General Practice. This is the largest of the OMA sections, with a potential of approximately 3,000 members, but it is chiefly concerned with the tariff and attracts little popular interest. It sometimes meets (to secure a quorum) at the time of the annual meeting of the Ontario Chapter of the College of Family Physicians. The President of the Ontario Chapter for 1967 has been a member of the OMA Tariff Committee for several years.

At a meeting of the Executive Committee of the CMA in Edmonton in June 1966 a brief was submitted by a group of general practitioners (chiefly from Alberta), and as a result a conference (including representatives from the College of Family Physicians) was later held at CMA headquarters. This meeting recommended the setting up of a CMA special committee on family practice to consist, basically, of delegates from the various provincial association general practice sections. This was agreed to and the Committee was given the following terms of reference:

- 1) To improve communications between provincial sections of general practice, other members of the profession and the public.
- 2) To provide the CMA Executive and General Council with the views of general practitioners on socio-economic and political matters.
- 3) To uphold the interests of general practitioners in respect to fee schedules.
- 4) To provide liaison with other general practitioner organizations such as the College of Family Physicians and the *Fédération des Omnipraticiens de Québec*.

The CMA has clearly stated that only matters of a political and economic nature are to come within the purview of this Committee, and that problems of education and training are to be left to the College. It should be noted, however, that the topics discussed at the first meeting of the Committee included: "attraction

of new physicians to general practice; the definition of a general practitioner; and the development of general practice in hospitals",²⁷ all of which are within the College of Family Physicians' sphere of interest.

We formed the impression that the College of Family Physicians — at least in Ontario — is essentially a younger man's organization (doctors in their late thirties and early forties). It takes time and determination to follow the College's educational program seriously, and it can also be costly (one doctor estimated about fifty dollars a day including overhead lost by his absence to attend a course, and this was almost certainly an underestimate). This is not to say that older men do not belong; merely that the future of the College probably lies with the younger activists who are "fed up with the encroachment of the specialists" (as one respondent put it) and who are anxious to reverse, or at any rate try to halt, the trend away from good general practice.

The Specialist Medical Associations

In 1881, the General Council of the Canadian Medical Association resolved as follows:

Whereas the system of specialism and specialists, which at present obtains to a certain extent in the Dominion, and which has developed to a very large proportion in the neighbouring republic, is for the most part the outgrowth of superficial professional education and a want of success as practitioners of medicine and surgery; therefore be it resolved,

That it is the opinion of this society that specialism should be discounted by the members of the society; and that specialists except in rare cases . . . should be treated and looked upon as irregular practitioners.

In one respect — outspokenness — general practitioners are certainly not what they were!

Today there is a multiplicity of specialisms, each with its own society or societies, and it is the general practitioners who are on the defensive. A partial list of specialist societies, many of which have Ontario equivalents, would include: the Canadian Anaesthetists' Society, the Canadian Association of Anatomists, the Canadian Association of Medical Bacteriologists, the Canadian Neurological Society, the Society of Obstetricians and Gynaecologists of Canada, the Canadian Ophthalmological Society, the Canadian Association of Radiologists, the Canadian Otolaryngological Society, the Canadian Paediatric Society, the Canadian Association of Pathologists, the Canadian Association of Physical Medicine and Rehabilitation, the Canadian Psychiatric Association, the Canadian Heart Association (cardiologists) and the Canadian Urological Association. There are also associations of specialists engaged in teaching and research, such as the Canadian Society of Clinical Investigations, the Canadian Association of Professors of Psychiatry and the Canadian Association of Clinical Surgeons. A comprehensive survey of

²⁷*Canadian Medical Association Journal*, Vol. 96, May 6, 1967, p. 1290.

specialist societies would be a study in itself. We shall mention two only. Both of them gave evidence before the Committee on the Healing Arts and both are probably fairly typical.

The Ontario Psychiatric Association²⁸ was founded in 1920 (as the Ontario Neuro-Psychiatric Association). In 1956 it was granted a provincial charter and reorganized under its present name. The objects are "to maintain an organization on behalf of the psychiatrists of Ontario for their mutual benefit, for the interchange of scientific information, and for the promotion of their professional welfare and usefulness; to represent the members in their relations with the government of Ontario, municipal governments, universities, medical associations, and other associations . . . with which the psychiatrists of Ontario from time to time may have relationships; and to publish journals and other literature for the dissemination of psychiatric knowledge". Full membership is for the most part restricted to practitioners licensed in Ontario who have been granted certification as specialists in psychiatry by the Royal College of Physicians and Surgeons of Canada. About two-thirds of the Ontario psychiatrists are members and most of them also belong to the Canadian Psychiatric Association. An interesting provision of the constitution permits members of the Ontario Psychological Association, the Ontario Association of Social Workers, the Ontario Association of Occupational Therapists and the Registered Nurses' Association of Ontario to become "affiliate members". The Association is governed by a small elected Council. There are no local chapters but there are sections within the Association: for example, sections on Child Psychiatry, Psychotherapy and Community Psychiatry.

The Ontario Association of Pathologists was established in 1938. Its objects are the advancement of pathology and its allied sciences, the maintenance of a high standard of proficiency and ethics among its members, the promotion of research in pathology, and the promotion of the scientific interests of its members. In 1965 it had 151 ordinary members (all but twenty of them in Ontario), twenty-eight associate members (all but five in Ontario) and a few life and honorary members. Ordinary members are licensed practitioners, resident in Ontario on joining, who hold a Royal College qualification in pathology "or some other recognized branch of laboratory medicine". The Association is governed by an elected Council and an Executive Committee.

The Local Medical Societies

It has been said²⁹ that when the Ontario Medical Association was founded its prime purpose was to serve as a liaison between the local medical academies and

²⁸Some of the Canadian societies have Ontario equivalents, of which this is an example; others use the facilities of the OMA. For example, the Canadian Association of Radiologists is divided into geographical "sections" of which there are four in Ontario; but at the provincial level itself, the radiologists are organized as the Section on Radiology of the OMA.

²⁹By Dr. Glenn Sawyer, in an article in the December 1966 issue of the *Ontario Medical Review*; see also Reply to Questionnaire B, Committee on the Healing Arts, October 1966, question 2.

the CMA. The situation today does not bear out that contention. As far as the Ontario doctor is concerned, the OMA alone acts as the official mouthpiece of organized medicine in Ontario; the CMA represents his wider interests, such as they are, across Canada; and the local medical society is his first point of social and professional contact with his fellow doctors. There is no strict hierarchy of *function*; rather, there are different levels undertaking different functions. It is not possible to speak as categorically about the division of influence — at least as between the local and the provincial levels — since this depends a good deal on the vigour of the local societies from place to place. There are now about sixty local societies in Ontario, but not all of them are active. Some are (or have been reduced to) little more than electoral divisions of the OMA; others were formed solely for the purpose of securing representation on the OMA and other privileges of affiliation. The last is particularly true of the medical societies in Metropolitan Toronto most of which are, in effect, the medical staffs of the large community hospitals under another name.

The effectiveness and influence of a local medical academy (which may, of course, vary over time) depends on many factors, including the circumstances of its birth, its location (for example, where there are medical schools and teaching hospitals, they tend to contribute disproportionately to the local medical elite), and the existence of at least a small group of active doctors in the neighbourhood. In the short time at our disposal we were able to sample only a few local societies (about one-sixth of all those in Ontario) and those chiefly along the Lake Ontario shore; but the societies surveyed did include two of the more important: the medical academies of Toronto and Hamilton.

Local medical organization in Metropolitan Toronto presents a curious and complex picture. The Toronto Academy of Medicine is in an important sense the core of this organization, with a membership that includes roughly three-quarters of all the doctors in the Metropolitan area; but the rise of new and largely hospital-centred societies has introduced some new dimensions. Metro Toronto is designated in the OMA By-Laws as District No. 11. This District comprises eleven territorial divisions (or nearly one-fifth of the total in Ontario) each of which has a medical society electing members to the OMA Council. Most of these are associations based on community hospitals that have applied for branch society status and have been given jurisdiction over a specified territory. Before the rise of hospital-based societies physicians tended to be represented on the OMA through the Toronto Academy. Now, however, the OMA jurisdiction of the Academy is restricted (technically) to the Central Toronto Territorial Division, which covers an area bounded by College and Dundas Streets on the south, Dufferin Street on the west, Bayview Avenue on the east, and (roughly) Eglinton Avenue on the north. Constitutionally, only doctors living or practising within this area are entitled to elect the OMA representatives of the Toronto Academy.³⁰ Fellowship of the

³⁰For electoral purposes there exists a fictitious entity, the Central Toronto Clinical Society, but this is really the Academy under another name. The Academy also *appoints* members to the OMA Council in its own right.

Academy, however, is not so restricted: doctors practising anywhere in Metro Toronto are eligible to be Resident Fellows, and doctors anywhere else in the province are eligible to be Non-resident Fellows.³¹ Hence, many Toronto doctors are members of both the Academy and another local medical society (and some members of the Academy are not Toronto doctors).³² Formally, they may vote for OMA delegates in only one society; and in an attempt to ensure this, the OMA requires its members to declare the territorial division in which they propose to vote. The regulation, however, is not easy to enforce.

The hospital-based character of the local societies in Toronto raises some questions. It means, for example, that the local doctor is represented by a body that overlaps with the medical staff organization of the hospital, even though he may have few (if any) privileges in that hospital. Moreover, since nearly half of the hospitals concerned are Group A hospitals, there is a tendency towards a specialist-teaching staff bias. In the Toronto East Medical Society, for example, the meetings are attended by Toronto East General Hospital³³ staff only, though membership is open to *all* doctors in the area. (In fact, only a small proportion of the hospital staff attends — the average attendance is said to be thirty to thirty-five out of a possible 240.)

Local academies that had an independent existence before joining the OMA might be expected to be more vigorous than those that were formed purely to take advantage of OMA affiliation. That is certainly true of the Toronto Academy. This was created in 1907 through the fusion of the much older Toronto Medical Society (reorganized in 1878 but actually with an ancestry going back to 1833 when the Medico-Chirurgical Society of Upper Canada was formed in what was then the town of York) with the Ontario Medical Library Association (1887), the Toronto Pathological Society (1899) and the Toronto Clinical Society (1892). From the first it was intended to be primarily an educational and scientific body. Its Charter reads in part:

The purpose of the Academy shall be the advancement of the art and science of medicine with its collateral branches; the promotion and maintenance of an efficient library and museum (*functions taken over from the Ontario Medical Library Association*); professional improvement; the cultivation of harmony and good feeling among its Fellows; and the promotion of the corporate influence of the profession in relation to the Community.³⁴

Only the last of these purposes, perhaps, hints at a political function for the Academy; and attempts to make it an arm of medical policy-making have on occasion led to strain and resentment. It is quite willing to enter into joint enter-

³¹The Academy claims that about a fifth of all the doctors in the province are members of the Academy.

³²Though they may be graduates of the University of Toronto.

³³Which, though a Group A hospital, was actually *not* a teaching hospital at the time of writing.

³⁴Words emphasized have been added.

prises of a non-political nature with the OMA (at present, it is encouraging the development of plans to build a joint headquarters) but it wishes to do so as a distinct association and not as a branch of the OMA.

It is governed by a twenty-six member council, about half of whom are elected and half serve *ex officio* (such as the officers, the chairmen of sections) with a small Executive Committee consisting of the President, Vice-President, immediate Past President, and the Honorary Secretary and Treasurer. There is a thirty-seven member nominating committee, nine members being elected from each of four districts in Metro Toronto with the President serving *ex officio*. It would seem that its principal job is to seek out people who are willing to serve, for there is a tendency for Executive and Council members to be recruited from a rather limited circle year after year. The staff of the Toronto General Hospital is heavily represented.

The Toronto East General Medical Society and the Toronto Western Clinical Society are perhaps fairly typical of the local societies in Toronto that were formed primarily to take advantage of OMA recognition. The Toronto East Society dates from the 1930's, the Toronto Western Clinical Society from the 1920's. The requirement of the Public Hospitals Act in 1960 that every hospital must have an organized medical staff (see Chapter 5) presented a problem for these societies. The staffs wished to maintain their status as a purely voluntary organization, though they realized that the organization would fare rather poorly in competition for members' time when the statutory medical staff arrangements came into force. This has proved to be the case. Despite poor attendance and the fact that most of the functions of the society have now been usurped by other bodies, the Toronto East Society continues to hold monthly meetings (from October to May), to publish a bulletin, and to maintain an extensive committee structure. The committees, however, are more or less dormant and the society appears to be kept in existence by historical momentum.

The Toronto Western Society adopted a rather different solution to the problem posed by compulsory staff organization: it became in effect a dual society. The Clinical Society began as a purely scientific, social and educational body with no political functions; and its members were represented on the OMA through the Toronto Academy of Medicine. By later becoming a branch of the OMA it opened its membership to all doctors in its area and accepted responsibility for OMA recruitment and publicity. Membership since 1960 has been compulsory for all members of the hospital staff, but it remains voluntary for all other doctors living or practising in the OMA division. Although non-members of the hospital staff seldom attend meetings of the society and, *per contra*, several members of the staff are not members of the OMA, the society continues to carry out its dual obligation as a compulsory hospital medical staff organization and as a branch of the OMA.

The Northwestern Toronto Medical Society is based on the general hospital of that name, which is a small Group B hospital. Here the local society is virtually

defunct, its functions having been taken over by the statutory medical staff organization. It appears on paper as the local branch of the OMA and as such is open to all doctors in the area; but "outsiders" never attend. Indeed, they would now find it hard to do so because, after some experiment with separate meetings at which attendance was very poor,³⁵ the practice has been abandoned (except for the annual general meeting of the society); such society business as there is to discuss is raised at the meetings of the medical staff of the hospital. Oddly, the executives of the society and the medical staff maintain a separate existence, and the president and vice-president of both sit on the Medical Advisory Committee of the hospital. Indeed, it was represented to us that the president and vice-president of the society were more representative of the "average doctor" than their opposite numbers from the medical staff!

The Hamilton Academy of Medicine bears a marked resemblance in aim and organization to the Toronto Academy, but it functions much less ambiguously as a branch of the OMA. Its territorial jurisdiction includes the whole of Wentworth County, and this is congruent with the area within which practising doctors are entitled to Resident Membership. It is jealous of its separate identity but it actively encourages its members to become members of the OMA; indeed, the OMA membership of the Academy has increased in the last five years from less than 60 per cent to more than 90 per cent, and in 1967 the Academy was awarded the T. C. Routley Challenge Shield, given annually by the OMA to "the most outstanding branch society". There is little reason to doubt that, at present at least, the Hamilton Academy functions locally as an influential propaganda and recruitment arm of the OMA, giving strong support to OMA policy.

So far we have discussed the local medical societies within the "Golden Horseshoe" only. A few remarks on some of the societies elsewhere in the province may therefore be in order.

The Leeds and Grenville Medical Society was established in 1933, explicitly as a branch of the OMA. Its membership includes the majority of the doctors practising in the two counties, and it is a fairly vigorous organization. Doctors in Gananoque, however, though formally within its jurisdiction, tend to look towards the Kingston Academy and usually attend the meetings there. Hence the Leeds and Grenville society is composed primarily of doctors from Brockville, Kemptville and Prescott. Meetings are normally held monthly, between September and June.

The Hastings and Prince Edward Medical Society appears to be both less active and less well organized than Leeds and Grenville. Although it has a listed membership of about eighty, it meets only once a year, primarily for the purpose of electing its officers and its delegates to the OMA Council (of which there are four, representing in the main the communities of Belleville, Trenton, Picton and Brighton). These men might be said to constitute the society between annual

³⁵Usually about half-a-dozen out of a possible 150.

meetings. But it is perhaps unwise, in measuring the cohesion and influence of an organization, to place too much reliance on the occurrence or non-occurrence of formal meetings, committees and the like. The Hastings and Prince Edward society has set up a simple telephone communication network which permits the president to call a list of doctors, each of whom then calls a further list. This practice was mentioned to us in the context of a discussion about the problem of "democratically" organizing a doctors' strike, but it serves here to emphasize that there are other ways of conducting business than by sitting around a table at a formal meeting.

Our studies suggest that the local medical societies as such are not particularly influential in the OMA policy-making process, though individual representatives may be. They are important as recruiting agencies, but not as centres for the discussion of OMA business. Political matters are left largely to the OMA Council and Committee structure and to headquarters, though local societies engage to varying degrees in filtering and interpreting OMA decisions to their members.

Their public relations function is not to be despised, and some societies are quite active, engaging in various kinds of community service. Until recently, the Toronto Academy provided a central referral agency or clearing house for patients seeking the services of a family doctor; but this has now been abandoned because of the shortage of general practitioners. Both Hamilton and Toronto Academies supply speakers for civic groups and representatives to paramedical organizations and welfare agencies such as the Victorian Order of Nurses, the Toronto Welfare Council and the Board of Health. The Toronto Academy plays an active part in the United Appeal Fund and the Hamilton Academy runs courses at the YM-YWCA and prenatal classes. It has also conducted a series of weekly open-line radio programs during which one of its members answered questions from the listening audience on heart disease, arthritis, allergies and other medical problems. The Toronto Academy Public Relations Committee (consisting of a group of past-presidents) has cooperated with the CBC in several medical programs. The other societies studied, lacking a central office and administrative staff, are more restricted. Toronto East General Society has arranged for its members to conduct medical examinations for school children free of charge. Other societies handle press inquiries and appoint representatives to civic groups.

Scientific and educational activities are looked upon by many societies as their most important function; indeed (as we saw) some originated specifically for the interchange of scientific views and information on the clinical aspects of medicine. The Toronto Academy holds monthly meetings at which papers are presented by Fellows or by out-of-town speakers from such institutions as McGill University and the Mayo Clinic, and these are usually reprinted in the Academy Bulletin. The Hamilton Academy holds five scientific meetings with out-of-town speakers and two clinical days a year. The Kingston Academy holds occasional clinical days and scientific meetings, sometimes in conjunction with the University. The Hastings and Prince Edward Society's meetings are confined to one a year at present.

As we shall see later, the local societies are expected to exercise some disciplinary functions and also to mediate in disputes between patients and their doctors; but they are not all active, at least formally.

Finally, but by no means least in order of importance, there is the social function. There are the usual fraternal activities: annual picnics, dances, golf and curling events, and so forth, sometimes organized by or in conjunction with the local medical wives association; and some of the larger societies have sick and fraternal committees to handle cases of misfortune. (The Toronto Academy actually offers group insurance covering accidents, sickness, life and income protection.) Some societies publish monthly bulletins. These things tend to be done on a less formal and ad hoc basis in the smaller societies. For example, when our representative was in Belleville, the vice-president of the local society was engaged in canvassing for a fund to help the widow of a recently deceased member.

One aspect of the social function deserves special notice, and that is the role played by the society in bringing together doctors from different and even rival groups in the locality. In Toronto, for example, there is much inter-hospital rivalry between the teaching hospitals and the non-teaching hospitals who feel that they suffer in prestige and government financing. The Toronto Academy is successful in subduing these antagonisms only to a limited extent, since it tends to be identified with the teaching hospitals, especially Toronto General, and with the University. However, the Political and Economic Committee of the Academy has sometimes played a useful role in resolving tensions and in coordinating the policy stands of the various hospitals vis-à-vis the Ontario Hospital Services Commission. The Hamilton Academy has members in five hospitals (only one doctor on a hospital staff in its area is not a member of the Academy) and it appears to perform this broader social function well. The Leeds and Grenville society draws upon two hospitals, Brockville General and St. Vincent de Paul. There is currently some friction between them, and the society provides a neutral ground where overlapping memberships and personal friendships can come to the fore.

In the words of Dr. H. E. MacDermot, the unofficial historian of the CMA, "the medical societies form a solid and indispensable element in the scientific and social aspects of medical life. If there are grass roots in medical affairs, it is among the societies that they are to be found."³⁶

The Federation of Medical Women of Canada

Until the last quarter of the nineteenth century it was almost inconceivable, at least to men, that a woman should wish to become a doctor. How were they to be trained? No girl, said *The Lancet*,

³⁶H. E. MacDermot, *op. cit.*, p. 154.

. . . who has been brought up in the sphere in which persons of refinement are to be found could dissect the different parts of a human body or listen to anatomical and physiological lectures in the presence of a number of young men without outrage to the delicacy and sense of modesty of both sexes.³⁷

Doctors believed that their world was “an unsuitable province of labour” for women and strongly resented the “unseemly invasion” when it came. Lay opinion was unalterably opposed. But nursing was somehow different: perhaps because, there, “indelicacies” could be discussed privately — that is, among women only; but also (when the men were honest) because nurses “were not required to exercise independent judgment.”³⁸

There were a few noble souls who braved this cultural ban, among them the formidable Elizabeth Blackwell, who graduated M.D. in New York in 1849; the English pioneer, Elizabeth Garrett (Anderson) who, in 1865 — four years before the publication of John Stuart Mill’s *On the Subjection of Women* — became the first woman to gain a registrable qualification in Britain; and Emily Stowe, the first woman doctor to practise in Canada, who qualified in the year of Confederation and set up her plate in Shuter Street, Toronto in the same year.

All had to face immense pressure. Elizabeth Blackwell’s passage was a stormy one; and Elizabeth Garrett was excluded from the Middlesex Hospital Medical School and had to continue her medical education privately. Mrs. Stowe had her application for entrance to the University of Toronto indignantly refused. “The doors of the university are not open to women and we trust they never will be,” said one member of the Senate. She was not granted a license by the College of Physicians and Surgeons of Ontario until 1880. Professors, among them the great Lister, refused to lecture to mixed classes, and segregated classes broke down. In the end women were forced to seek their medical education abroad (Canadian women in New York, for example), or create their own medical schools. In 1874 the London School of Medicine for Women was founded; a decade later another pioneer medical woman, Sophia Jex-Blake, was instrumental in founding a similar school in Edinburgh. In Ontario, after an early struggle, a Women’s Medical College was established in 1883 at 291 Sumach Street, Toronto. The first student enrolment was three, and one of the lecturers was Dr. Stowe’s daughter, Dr. Augusta Stowe Gullen. Ultimately, about 150 women graduated from the College, the majority receiving their degrees from Trinity University until the University of Toronto opened its doors to them in 1905. There remained considerable prejudice in the Toronto hospitals and, as a result, what was later to become the Women’s College Hospital was begun.

Today there is little open prejudice against practising women doctors; indeed many patients, including some men, prefer them. Allegations of discrimination in

³⁷The *Lancet*, Vol. II, 1870, p. 828.

³⁸W. J. Reader, *Professional Men*, Weidenfeld and Nicholson, London, 1966, p. 181.

the admission of women to medical schools are made; but if it exists, it is due less to the belief that their admission would be unseemly than to the fear that they are likely to get married and to be lost to the profession after a long and expensive training. It was suggested to us by one responsible source that, for entry to medical school, a woman has to be better than a man (i.e., a higher grade average is required) and that if a man and a woman had equal grades the man would get in. Another respondent (a woman doctor) told us that in one of the Ontario medical schools all women applicants are interviewed and the university has a rigid policy about discussing a girl's future: "the admissions people" try "as far as possible to get the girl to promise to use her medical qualifications and not get married". In another, "the Dean fills up the quota with men and then adds a few women". She "does not feel that there is any open discrimination . . . but believes there still is under the surface — part of the WASP background and the Presbyterian attitude to women."

The peculiar problems of medical women (to use their own inelegant and rather odd term) are discussed more fully later, but it may not be inappropriate at this point to refer to a speech delivered by the Minister of Health at the Tenth Congress of the Medical Women's International Association in Toronto in July 1966. Pointing out that the number of women entering medical schools in Canada has increased by more than half in the past ten years, Dr. Dymond went on to argue that, although the number applying was still far too small, the proportion of acceptances to applications was, in fact, higher for women than for men. This does not by itself dispose of the discrimination argument, for it ignores the possibility that some women may be deterred from applying because they think they have no chance of success, and also the possibility that the standards of the worst-qualified women applicants may be considerably better than those of the worst-qualified male applicants. This is not, however (as the Minister pointed out), the crux of the problem. Recriminations about possible bias in the medical schools will solve nothing; more to the point, it is necessary (in Dr. Dymond's words)

. . . to design community health programs and services flexibly enough to utilize the talents of medical women on a part-time basis where need be, to provide opportunity for up-dating those who are absent from practice for lengthy periods of time, and (to establish) temporary postings available to women for meeting immediate and specific health problems and needs.

The women doctors' professional association, the Federation of Medical Women of Canada, was founded in Ottawa in 1926. It was originally a group of general practitioners, but later it was thought a good idea to get the specialists interested; and, indeed, the President in 1967 was a specialist in internal medicine (she was President of the Ontario Branch of the Federation the previous year). Of the 1,700 or so women doctors in Canada, about a quarter are members. All new graduates are enrolled automatically and become associate members without payment of a fee. They pay a reduced rate while they are interning and become full members when they enter practice. Undergraduates are admitted to junior membership, and

it is one of the major functions of the provincial branches (of which the Ontario Branch is the strongest) to maintain contact with them.

The organization appears to be run fairly informally. There is a President elected annually, a Past President (who acts as adviser to the President), a President-Elect and (notionally) a Vice-President from each province. The Secretary is part-time. The chief meeting of the year, the Annual General Meeting, takes place at the same time as the CMA annual convention, for which the Federation arranges certain social activities. A newsletter is distributed to members from time to time.

In general, the Federation now tries to help women doctors in ways other organizations cannot or will not. There is a Scholarship Fund (the Maude Abbott Fund), which is available to medical women graduates and undergraduates in financial need. Assistance is given in the form of loans (bearing a rate of interest of 5 per cent) which are repayable within seven years. The Federation tries to act as a focal point for medical women both socially and professionally. As a pressure group it tries to bring the special needs of women doctors to the attention of the larger and more powerful organizations. Relations with the CMA are cordial but there seem to be few contacts with the OMA. There are Chapters in Toronto, Kingston, Ottawa and London, and their main function is to get to know the women students in the local medical school and persuade them to become members.

In her 1967 Message to the members, the President had this to say:

I belong to many organizations that are basically run by men.³⁹ I have yet to see any men's organization particularly stand up for women. Certainly there is not the discrimination there used to be against women, but there still is discrimination, and I feel very strongly that there are certain things that women can do for other women that men's organizations cannot do.

We shall see later what these may be.

The Canadian Association of Medical Students and Internes (CAMSI)

This is not a professional association in the strict sense because its members are not yet professional people; but it should not be omitted from an account of the formal influence structure, though its influence is small.

CAMSI was founded in Winnipeg in 1937 when members of the medical undergraduate societies of several Canadian medical schools came together to plan a national conference. This was held in Toronto the following year and was attended by delegates from Toronto, McGill, Western Ontario and Queen's Universities. There are now ten medical schools in membership (there are fifteen medical schools in Canada at present). CAMSI itself is affiliated with the CMA, which

³⁹A woman Director of the OMA was not elected until 1965.

provides secretarial assistance (though the headquarters of the organization is now in Ottawa in office space provided by the Association of Canadian Medical Colleges). The French Canada medical schools, Laval, Montreal and Quebec, were formerly members but have now withdrawn. The total membership in 1967 was 4,320 medical students (of whom 1,414 were in Ontario medical schools) and about 1,500 internes (of whom about a third were interning in Ontario).

CAMSI is governed by a Council consisting of the president of, and one other member elected by, each of the constituent societies; and by an Executive Committee which is chosen from one medical school each year in rotation (i.e., the entire Executive in any given year is drawn from one medical school in order to facilitate contact). There is an Executive Director who acts as a kind of roving assistant to the President and as the chief organizer.

There are committees for the various activities of the organization which include a clearing house for interne placement, a student exchange scheme with foreign countries, and the organizing of summer schools. CAMSI also publishes a journal. Since it deals only with matters of national concern, it hopes to set up provincial associations; but at present there is only one, the Ontario Association of Medical Students and Internes, and this is still in a rudimentary stage.

The main aim of CAMSI is to improve the material welfare of medical students and internes, and to represent their viewpoint to all bodies concerned with medical education. The summer school is designed to interest the members in the medical problems peculiar to the more remote areas of Canada and the developing countries. About sixty students are sent away for about three weeks each year. In 1966 they went to Haiti, and in 1967 to Inuvik. This program has the support of the CMA, the Association of Canadian Medical Colleges, the Department of Health and Welfare, and a leading drug company (which helps to finance it). This year the Government of Ontario made available \$100 for each Ontario student taking part. Part of the object of the program is to encourage medical students to spend some time in these remoter areas after graduation.

The organization's concern for the welfare of the interne brings it into fairly frequent contact with the Ontario College of Physicians and Surgeons. But the relationship appears to be very formal, and CAMSI is critical of the College's policies. This matter is touched upon later in the section dealing with undergraduate medical education.

Chapter 4 The Colleges and Licensing Bodies

*Honour a physician with the honour due unto
him for the uses which you may have of him:
for the Lord hath created him.*

— *Ecclesiasticus*, 38: 1

The regulation of medical practitioners and specialists is discussed at length in Part Three. Here we are concerned only with the structure of the licensing bodies.

The College of Physicians and Surgeons of Ontario

The first Act incorporating the medical profession of Ontario was passed in 1866. This was the Medical Act of Upper Canada, and the governing body was known as the General Council of Medical Education and Registration. With the coming of Confederation, the Act was repealed, and the Ontario Medical Act, 1869, created the College of Physicians and Surgeons of Ontario. Its major functions under the present Act¹ are three: first, to set the minimum requirements for premedical and medical education in the province; second, to license doctors to practise medicine in the province and to prosecute the unlicensed; and third, to control the ethical behaviour of practitioners and conduct disciplinary proceedings. Every medical practitioner registered under the Act becomes a member of the College.

The College is governed by a Council consisting of the Minister of Health ex officio,² a member chosen by each of the province's medical schools and twelve elected members. The latter are chosen by territorial divisions, of which there are ten, Metropolitan Toronto returning three members. The term of office for all members, other than the Minister, is four years but they may be re-elected. If a member for a division ceases to live in that division during his term, he vacates his seat and a by-election is held.

The Council meets normally twice a year and between meetings powers are delegated to an Executive Committee appointed annually by Council. This consists of the President of the College, the immediate Past President, the Vice-President and two other Council members. Three committees handle ethical and disciplinary questions: the Code of Ethics Committee, the Complaints Committee and the Discipline Committee. A Legislation Committee keeps the Medical Act and the Col-

¹Revised Statutes of Ontario, 1960, Chapter 234, as amended.

²This is more than nominal: the present minister actually attends (but he is, of course, a doctor).

lege's Regulations under review. A Committee on Education and Registration considers individual cases referred by the Registrar (applications for licensing, and so forth), and attends to educational policy matters generally. As already noted, there is a Joint Advisory Committee with the OMA, to which matters of contention between the two bodies can be referred, hopefully for resolution.

The College is supported financially by the fees paid biennially by its members for the privilege of registration, and by monies paid for certificates and examinations.

The College has two representatives on the Medical Council of Canada but is not directly represented on the Royal College of Physicians and Surgeons (the specialist-qualifying body), the governing body of which is composed exclusively of specialists. Under the terms of the Medical Act, it is the Ontario College that licenses specialists within the province; but in practice it recognizes as specialists in Ontario only those who hold Certification or Fellowship of the Royal College.

The College is represented on the Senate of the University of Toronto; it is jointly represented (with the OMA) on the Ontario Council of Health; and it sends observers to meetings of the Council of the OMA and the CMA, and representatives to conferences of the Association of Canadian Medical Colleges and the annual meetings of the Federation of State Medical Boards of the United States. The Registrar of the College has for some time met twice a year with his colleagues from the other provincial licensing bodies, usually at the time of the meetings of the Medical Council of Canada, at which time common licensing problems are discussed. These meetings have now been formalized by the creation of a Federation of Provincial Licensing Authorities (the Registrar is the Vice-Chairman of its body), which is referred to later in this chapter and again in Chapter 8. Finally, it is the duty of the territorial (elected) representatives on the College Council to attend the annual meetings of the OMA Districts and report to them on the business of the College. These district meetings of the OMA are used, when required, for the purpose of nominating candidates for election to the Council of the College. There is thus much cross-representation and consultation.

It is sometimes alleged that the College represents the "Establishment" of the Ontario medical profession; or, to put the matter more precisely, that there is a Toronto-based Establishment, of which the College forms part, supported by a number of sympathetic local medical "elites" which dominates the entire Ontario profession. This is a matter to which we give further attention in Chapter 7, but a brief comment may be in order here.

In the period under review (1964-1967) the Council of the College had sixteen members (excluding the Minister.) Under the constitution one quarter of these places "represented Toronto" in some sense: namely, the three "territorial" representatives and the member nominated by the University of Toronto. In this period sixteen doctors filled the twelve territorial seats. Seven were graduates of the University of Toronto, four of McGill, three of Queen's, one of the University

of Western Ontario, and one of the University of Oxford (England). Almost all were either certificated specialists or Fellows, or otherwise held hospital staff appointments. The vast majority thus practised some speciality by virtue of special interest and experience, though not all actually possessed qualifications from the Royal College. Five doctors filled the four "university medical school" seats during this time. The universities from which they graduated were: McGill, Toronto, Queen's, Dalhousie and Aberdeen (Scotland). Two were professors in preventive medicine, two were in internal medicine, and one was a urologist.

Of four major committees, Discipline, Education, Complaints and Ethics, only the first two were in existence for the whole of the period. The five places on the Discipline Committee were held by fourteen doctors, but the Chairmanship was held by the same doctor throughout. The five places on the Education Committee were held by thirteen doctors, and the chairmanship changed hands once. The three places on the Complaints Committee were filled by seven doctors and there were three different chairmen. Four doctors held the three places on the Ethics Committee, and the chairmanship (which did not change) was held by the same doctor who was chairman of the Discipline Committee.

The President for 1963-1964 was Dr. J. W. R. Webster, a graduate of the University of Toronto and a surgeon. For many years on the staff of the Ottawa Civic Hospital and an active member of the Ottawa Academy of Medicine, he was first elected to the Council of the College in 1955. Dr. Webster's successor (for 1964-1965) was Dr. E. R. S. Wyatt, one of the youngest members of the college ever to hold this office, a graduate of McGill and a member of the Active Staff of the Kitchener-Waterloo Hospitals. He was first elected to the Council in 1956. The President for 1965-1966 was Dr. D. L. Wilson, also a relatively young man, a graduate of Queen's, a professor of medicine in that University and the Queen's representative on the Council. For the 1966-1967 term Dr. Wilson was succeeded by Dr. Ian MacDonald, a graduate of Dalhousie, Professor and Associate Dean of Medicine at the University of Toronto, and the University's representative on Council. The President at the time of writing is Dr. A. R. Turnbull, a graduate of McGill and a general practitioner, who for many years has been closely associated with the OMA and has long served as a member of the Council of that body. He was first elected to the Council of the College of Physicians and Surgeons of Ontario in 1960.

The Royal College of Physicians and Surgeons of Canada

The Royal College is not a licensing body in the strict sense. Fellowship and Certification are merely evidence that the holder has successfully pursued an approved course of postgraduate education. However, as we have already noted, in Ontario the Royal College imprimatur is the only proof of specialist training that is recognized by the provincial licensing authority.

The College was incorporated in 1929 by an Act of the Canadian Parliament after a long debate in the profession about the desirability of establishing such a body.

Before 1930 Canadian doctors who sought specialist recognition had to take either European (particularly British) or American qualifications. Initially many doctors were necessarily admitted to Fellowship without examination, on the basis of qualifications already possessed, but gradually these charter Fellows were joined by others who obtained their Fellowship through examination (started in 1932). Certification as a stage towards Fellowship was introduced in 1937, though actual examinations for this purpose were not begun until 1946. Originally only two specialties, general medicine and general surgery, were recognized; but the list has been steadily enlarged, and today there are about twenty-five.

The College is administered by a Council of Fellows. There are twenty-four members, twelve from each of the two divisions, the division of medicine and the division of surgery (Fellows of the Medical Division are referred to as Fellows of the Royal College of Physicians of Canada; and Fellows of the Surgical Division, as Fellows of the Royal College of Surgeons of Canada). The members of Council from each division are elected for four-year terms by and from the Fellows of that division by geographical constituencies. There are five of these: British Columbia and Alberta, Saskatchewan and Manitoba, Ontario, Quebec,³ and the Maritimes. Two members in medicine and two members in surgery are elected from each of these, except Ontario and Quebec, each of which returns three in medicine and three in surgery. Thus Ontario specialists make up a quarter of the total membership of the Council. The President is elected by and from the Council, holds office for two years, and is alternately a surgeon and a physician. There are two Vice-Presidents, one from each division, and they also hold office for two years. An Executive Committee acts for the Council between meetings which are held two or three times a year: it consists of the President, the immediate Past President, the two Vice-Presidents, and one other member of Council, plus the Secretary and Honorary Treasurer. The administrative headquarters employs about twenty people. There are no local branches or chapters, but there are occasional regional meetings.

The most important committees are as follows. The Committee on Credentials evaluates the medical qualifications and graduate training of candidates applying to take the examinations of the College; it assesses the training programs of candidates in training; and it recommends to Council appropriate training regulations in the various specialist branches of medicine and surgery. The Committee on Examinations is responsible to Council for all matters pertaining to the conduct of examinations. The Committee on Approval of Hospitals accredits (subject to Council) those hospitals in Canada that are to be allowed to provide resident

³Quebec now has its own specialist qualifying body.

training in the medical and surgical specialties. It reviews existing hospital programs and considers applications to establish new ones. The Committee on Ethics is discussed in Chapter 10. There are also a Committee on Specialty Development, which advises the Council on new specialties which may be recognized by the granting of appropriate certification; and a Committee on the Supply and Distribution of Specialists, the function of which is explained by the title.

In addition there are advisory specialty committees in each of the twenty-five fields of specialization currently recognized by the Royal College. The Council of the College appoints a chairman for each of these, and the various national specialty associations supply the committee membership. These committees may advise Council on all matters relating to their own field, including training regulations, qualifications of candidates, approval of hospitals, and examinations.

It will be apparent from this brief account that the chief function and largest activity of the Royal College is the conduct of the specialty examinations, and, related to this, the fixing of standards of qualification and training, the approval of hospitals for advanced graduate training, and the assessment of the eligibility of applicants. It also has some responsibilities for continuing education (these are touched upon later in this report).

As with the Ontario College, the chief sources of finance are fees (including examination fees) and the annual dues of the Fellows. The Royal College also receives a grant from the federal government in aid of its hospital residency training program.

In 1966 there were 3,355 Fellows and 7,847 Certificate holders in Canada. Of these, 1,277 Fellows and 2,945 Certificate holders were resident in Ontario — a very high proportion in each case. The location of Fellows as of April 1966 was

British Columbia	9.3%	New Brunswick	0.8 %
Alberta	6.3%	Nova Scotia	2.4 %
Saskatchewan	3.0%	Pr. Edward Island	0.14%
Manitoba	5.0%	Newfoundland	0.5 %
Ontario	37.0%	U.S.A.	6.5 %
Quebec	26.0%	Elsewhere in world	2.5 %

It should be noted that Certificate holders are not members of the College and, moreover, have had no special designation comparable to the F.R.C.P.(C) and F.R.C.S.(C). The College By-Laws have been amended recently to allow them closer association, including representation on the Council by non-voting representatives, and the right to use letters after their names identifying them as certificated specialists. It is perhaps worth noting at this point that the medical insurance agencies play a certain *de facto* role in the recognition of specialists because they decide to whom they are willing to pay specialist fees. At the moment, PSI and OMSIP recognize as evidence only Royal College certification.

The College is not officially represented on the governing bodies of the universities and medical schools, and it has no direct influence on undergraduate medical curricula. It has substantial influence at the graduate level⁴ since it helps to shape the curricula for the examinations in the various specialties and approves the training arrangements in the teaching hospitals. It has a non-voting representative at the meetings of the Executive of the Association of Canadian Medical Colleges.

The Medical Council of Canada

The establishment of a minimum standard of competence and of a uniform method of medical registration throughout Canada was a long task, one that was completed only recently. A major step on the road was the setting up, in 1912, of the Medical Council of Canada and the passing in that year, after many years of struggle, of the Canada Medical Act.⁵ The functions of the Council are to conduct examinations leading to a qualification in medicine that will be acceptable to all the provinces, and to maintain a Register of all such qualified practitioners. The difficulties are obvious: medical registration is a provincial function and every province has its own standards and its own registration authority. The problem was to superimpose some uniformity on diversity. In Ontario, candidates for the MCC examinations are sponsored by the College of Physicians and Surgeons and must possess an Enabling Certificate from that body before they can write them. The examinations are conducted conjointly with the final examinations for the M.D. in the medical schools. The Council has no power to fix premedical requirements nor in any way to interfere in the fixing of conditions for obtaining a provincial licence to practice.

The Council is composed of three members appointed by the Governor in Council, each of whom must reside in a different province; two members representing each province elected by the appropriate provincial licensing authority; one member from each medical school elected by that school; and one member (formerly three members) elected by the homeopathic practitioners of Canada. The term of office is four years, with provision for re-election. The Council elects a President, two Vice-Presidents and an Executive Committee, and appoints a Registrar. During the period 1964-1968, the two Ontario representatives on Council included the Registrar of the Ontario College.

The important committees are as follows. The Qualifications Committee considers all matters relating to educational requirements and makes appropriate recommendations to Council. Each province has one representative on this Committee, and each medical school is represented (by its member on Council). The

⁴Though what proportion of this is attributable to the College as such and what to the appropriate specialist society in advisory relationship to the College (see above) is difficult to assess.

⁵Largely due to the efforts of Sir Thomas Roddick of the Montreal General Hospital, one of six Canadians who studied medicine under Lister and an early advocate of Lister's methods of antiseptics.

Rules and Regulations Committee consists of one member from each provincial licensing body. Its functions are self-evident. The Discipline Committee, consisting of five members, considers all disciplinary cases arising within the provincial councils' jurisdictions and decides whether or not they should lead to erasure from the Medical Council of Canada Register. There is also a Finance Committee and a Nominating Committee.

At each annual meeting the Council formally appoints a Main Board of Examiners, which at present consists of five panels: one in Medicine, one in Obstetrics and Gynaecology, one in Surgery, one in Public Health and Preventive Medicine, and one in Paediatrics. Oral and Clinical Examiners also are appointed for each of the centres in which the examinations are held. No member of the Council may act as an examiner. About fifty examiners are employed part time on the Main Board (which sets and marks the papers), and about two hundred oral and clinical examiners take part in examining at the local centres.

The Council has no local or branch organization, but its work obviously requires close and continuous consultation with the provincial licensing bodies and with the medical schools. The number of practitioners on the register at the present time is about 25,000.

The Federation of Provincial Medical Licensing Authorities of Canada

This is a new body, set up in 1968. The inaugural meeting was held in Montreal on February 7 and 8, with the College of Physicians and Surgeons of Quebec acting as hosts. The purpose of the organization is to give more substantial form to the long-standing informal meetings of provincial Registrars mentioned above. Each of the ten provincial bodies was represented at the meeting by a member of its Council and by its Registrar; and officials of the Medical Council of Canada and of the Royal College of Physicians and Surgeons of Canada were present by invitation.

The objects of the Federation are, broadly, three: to promote uniformity among the various provincial licensing authorities in all matters relating to licensing; to promote a better understanding of the functions of the licensing authorities among the medical profession, the public and governments; and to act as a sounding-board for joint action. The Federation will be advisory only and will not have power to commit the individual licensing authorities to a course of action to which they are opposed.

The members of the Federation will be the provincial licensing authorities, each of which will pay an annual fee based on the number of fully registered practitioners resident in the province and will be entitled to two representatives: one member of the Council of the authority and its Registrar. Medical organizations with closely related interests (presumably including the Royal College and

the MCC) may be invited to become Associate Members. Each associate member will be entitled to send two representatives to meetings, but they will not be allowed to vote or hold office. Meetings will be held at least once a year.

This is a praiseworthy move on the part of the licensing authorities in view of the presently existing variations and discrepancies in the licensing provisions from province to province. In time regulations may well be tightened by the more permissive provinces (such as Prince Edward Island and Newfoundland) and modified by some of the more restrictive (such as Ontario, British Columbia and Quebec). It is notable that the most stringent provisions operate in those provinces that produce the most doctors. The details are given in Chapter 8.

Chapter 5 Medical Organization in the Hospital

A godly, righteous, and sober life.
—Book of Common Prayer

An account of the “power structure” of organized medicine in Ontario (indeed, in Canada as a whole) would be seriously incomplete without reference to the medical staff of the hospital. Sociologists, we are told,

... have distinguished three “typical” eras of hospital management. First comes the era of trustee or committee control, associated with the enlistment of financial support for the foundation of hospitals. Then, as the hospital develops into a centre of scientific medicine and a focal point of medical education and research, there inevitably ensues a period of medical paternalism and of domination by doctors. Finally, because of the mounting complexity of hospitals, the increasing intervention of governments in their planning and management and the urgent need to invest in “community” as distinct from “hospital” medicine, a marked trend towards control by the administration becomes evident.¹

This is what sociologists call an “ideal” typology: that is to say, it is *generally* true, not applicable to the real world without modification but close enough to it to enable us to organize our ideas about it properly. It would be fair to say that Canadian hospitals are now firmly located in the second era and may already be moving into the third.

The concept of “the medical staff” in Canadian hospitals is predicated on the right of doctors to organize themselves so as to regulate their dealings with each other, with their patients, with the Board of Trustees who legally govern the hospital, and with the community at large. Indeed, this is not only a right but a necessity, given the peculiarly voluntary nature of the relationship between the Board of Trustees and the doctors, a relationship that stems from an earlier time when hospitals were generally small and undifferentiated. The Executive Director of the Canadian Council on Hospital Accreditation outlines the rationale in the following way.

The Board of Trustees is legally and morally responsible for the medical care that the patient receives in the hospital. But, with some exceptions (such as

¹T. D. Hunter, “Self-Run Hospitals”, *New Society*, September 14, 1967, p. 356. Mr. Hunter is Group Secretary and Treasurer, Board of Management, Royal Edinburgh Hospital in Scotland. See also his “New View of the Hospital”, *The Lancet*, Vol. II, 1963, p. 933.

pathologists, radiologists and house staff), it does not itself employ the doctors who work in it. Moreover, in most cases, the doctor does not devote his whole time to hospital work: he has an outside practice (in the smaller hospital he is quite likely to be a general practitioner), or he teaches in a medical school and does research.

The Board does not appoint a medical staff *per se*: it appoints doctors who thereby have permission to use hospital facilities The individual doctors so appointed voluntarily organize themselves as the medical staff of the hospital, and the Board then delegates authority to that medical staff It does not give authority to (individual?) doctors, but to the medical staff.²

Permission to use hospital facilities is granted by the organized medical staff, or at any rate on their advice.

Thus, according to this view, the hospital is a number of doctors, voluntarily and individually giving part of their time to tend their patients in a convenient central place where facilities (nurses and so forth) happen to be available. The doctors are free-lancers. The patients are not the hospital's, or even the medical staff's, patients:

They are the doctors' patients. We must remember this. The doctor-patient relationship must be respected (even) in hospitals.³

On this argument, the doctors *must* organize: to protect their professional standards by regulating admission to hospital privileges and by scrutinizing the work of their peers; to protect their patients; and perhaps also (though this is less readily admitted) to protect themselves against the possible encroachments of lay control.

In their brief to the Committee on the Healing Arts, the CCHA related their accreditation program (which is described in other places in this report) to the promotion of "a distinct philosophy relative to hospital function". This philosophy assumes, *inter alia*, that "a hospital is essentially a place where individual physicians' resources are augmented".

It may be that this correctly states the formal position as set out in the Ontario Public Hospitals Act and in the important Regulation 523 made under the authority of that Act. There is no doubt that it correctly interprets the policy position of the CCHA, which has done undeniably fine work in regulating and raising the standards of patient care in hospitals across Canada. But it may be doubted whether it reflects the true nature of the modern hospital, except perhaps the small local hospital. A modern hospital of any size is no longer "a place where individual physicians' resources are augmented": it is a big organization and an organization that (whatever the legal situation may be) *employs* doctors, as well

²Dr. William Ivison Taylor, "Hospital Medical Staff By-Laws: An Instrument of Self-Government" (sic), *Canadian Medical Association Journal*, Vol. 93, September 18, 1965, p. 653. Emphasis added.

³*Ibid.*

as a great many other professional and sub-professional people. Moreover, as medicine develops, the doctor becomes less and less the sole, or even the pre-dominating, expert in the hospital; he becomes only one of a team of experts and not even "captain of the team",⁴ even though the problem may be mainly medical.

Medical staff organization is required by Ontario law. Regulation 523 ("Respecting Hospital Management") requires that every hospital shall be governed by a board of management. These boards are constituted in various ways, elected or appointed, in accordance with their charters; they are the products of local circumstance, and the Regulation takes account of this fact. As the Executive Director of the Ontario Hospital Association puts it:

Our hospitals came into being, not through the actions of government but through the initiative of religious orders and community-minded lay groups, who constructed them, operated them, and — when the need arose — expanded them. As time went on, of course, the provinces passed Acts to serve as legal guidelines for the local hospital boards, and both the provincial and the federal governments began making a financial contribution to the cost of new construction. However, the network of hospitals now in existence in Canada cannot be chalked up to the credit of any government. Instead, in a very real way, it stands as a credit to the voluntary agencies that brought the hospitals into being, and to the trustees that governed them. All that government has really done since then is to build upon the sound foundations of hospital care that were laid by independent citizens.⁵

Some of these boards are very large. For example, the Board of Governors of the Kingston General Hospital numbers about 100 people, including the Mayor of the City, the Principal of the University and other prominent people in the locality. It meets only once a year, however, and the management of the hospital is, in effect, in the hands of a much smaller Management Committee drawn from the ranks of the Governors.

Ultimate lay control of the hospitals is an important factor underlying any consideration of medical staff organization.

In hospitals of 100 beds or more the president and vice-president of the medical staff of the hospital and one other officer of the medical staff⁶ must be members of the Board of Trustees, with full rights and responsibilities. One of the first duties of the Board is to pass by-laws "that provide for the appointment and functioning of . . . a medical staff". It is these Medical Staff By-Laws with which we are particularly concerned here.

⁴This phrase was used by Dr. Taylor during the Committee's hearings.

⁵R. Alan Hay, "The Trustee-Government Relationship in Hospital Management", *Canadian Hospital*, August 1967, p. 51.

⁶The chief of the medical staff, the secretary of the medical staff, or the chairman or vice-chairman of the Medical Advisory Committee.

Regulation 523 lays down certain fundamentals that must be adhered to in drafting the by-laws, but hospital trustees have other assistance. The OMA has model by-laws; so has the Ontario Hospital Association; and the CCHA makes many suggestions, based on its experience of a great diversity of hospitals across Canada. (For purposes of accreditation the hospital must have medical staff by-laws that meet the Council's standards.) Under the Regulation all hospitals must have a Medical Advisory Committee (in the case of Group A, university-affiliated hospitals, constituted in accordance with provisions in the agreement between the hospital and the university with which it is affiliated), a Credentials Committee and a Records Committee. Where there are ten or more doctors on the active staff of the hospital the Regulation requires an Admission and Discharge Committee, and a Tissue or Tissue and Medical Audit Committee as well.

The Medical Staff By-Laws must provide that the Medical Advisory Committee make recommendations to the Board of Trustees concerning *every* application for appointment or reappointment to the medical staff;⁷ the hospital privileges to be granted to each member of the medical staff;⁸ the dismissal, suspension or restriction of hospital privileges of any member; and the quality of medical care provided. The Regulations further require that the whole medical staff hold monthly meetings, except in prescribed circumstances;⁹ and that there should be an annual election, by the whole medical staff, from among themselves, of a president, vice-president and secretary of the medical staff. There are also detailed requirements as to the keeping of medical records and the performance of certain clinical duties.

In order to obtain a clearer picture of the actual working of hospital medical staff organization we interviewed medical directors, chiefs of staff and administrators in a sample of hospitals of different sizes and types. As might be expected, our general findings were that the smaller hospitals had a more informal organization, with greater influence exercised by the medical staff as a whole rather than by the Medical Advisory Committee; and that the significant differences between hospitals in this respect were to be found less in the by-laws themselves than in the way they are operated. What follows is based on these interviews and on a careful examination of the medical staff by-laws in each case.

Toronto General Hospital

Toronto General, a very large hospital in downtown Toronto, serves a huge population and has a long-standing affiliation with the University of Toronto Medical School. The medical staff numbers about 450 and is divided into four main categories: consultant, active, associate and courtesy. The consultant staff may

⁷And the dental staff, where there is one.

⁸And dental staff.

⁹For example, in large general hospitals (where authorized by the Board of Trustees): but in such a case there must be regular meetings of the staff *by departments of the hospital*.

attend private patients and act as consultants for *any* patients at the request of the attending physician. A member of the active staff (a full member of the medical staff, so to speak) has full privileges; he is not allowed to serve on the active staff of another hospital unless he obtains the permission of the trustees; and his hospital practice is limited to work within the department to which he has been appointed. A member of the associate staff may attend private patients, and public patients in the Outpatient Clinic; and he may "participate in the study, investigation and treatment of patients" in the public wards under the supervision of a member of the active staff with whose department he is associated. A member of the courtesy staff may attend private patients only, and only in the department to which he has been appointed. Chief residents and residents are appointed in the same manner as active staff and have the same privileges, except that of admitting patients to the hospital. Assistant residents and internes may assist in the care of patients under supervision. All appointments are on a year-to-year basis; retirement is at sixty-two for active staff (there is a minor exception for heads of departments and divisions) and seventy for consultant, associate and courtesy staff. Under the terms of an agreement made between the university and the hospital in 1910, all appointments to active and associate staff are made on the recommendation of a Joint Hospital Relations Committee consisting of representatives of the hospital and the Medical School. No member of the active staff may be dismissed without its consent.

The Medical Advisory Board, which "governs" the medical staff, consists of the heads of departments (all of whom are joint appointments with the Toronto Medical School), the Dental Surgeon-in-Chief and elected members of the medical staff. Liaison with the Board of Trustees is secured by the presence on that body of the Chairman and Vice-Chairman of the Medical Advisory Board (as required by law), and through a recently appointed Joint Conference Committee which is intended to iron out disagreements and act as a two-way channel of information.

The Medical Advisory Board has a number of committees. In addition to those it must have (Credentials, Medical Records, Tissue), there are committees on Internes, Pharmacy, Transfusion, Laboratory and Library. Normally, only members of the active staff may serve on these committees. Since this is a teaching hospital, the Credentials Committee is limited to the consideration of appointments to the courtesy staff.¹⁰ The normal procedure is for the Credentials Committee of a hospital to recommend what privileges a doctor is to have in the hospital; but in a teaching hospital such as Toronto General where the doctor is appointed to a department, the head of the department makes this decision. The Interne

¹⁰To summarize: consultants are appointed by the Trustees on the advice of the MAB; active staff and associate staff by joint agreement between the Medical School and the hospital; chief residents and residents in the same manner as active staff; assistant residents and internes by the trustees on the recommendation of the MAB after scrutiny by the Interne Committee; courtesy staff by the trustees on the recommendation of the MAB after scrutiny by the Credentials Committee.

Committee scrutinizes applications for internship and assistant resident appointments. The Medical Records Committee advises on the maintenance and use of the hospital medical records (an important issue to which we return later). The Pharmacy Committee advises on the control and use of drugs in the hospital. The functions of the other committees are explained by their names; but a comment is necessary on the Tissue Committee because it raises a matter of general interest.

A Tissue Committee is appointed as a standard practice in all but the smallest hospitals so that there should exist a quality control, operated by the doctors themselves, of the work of all surgeons admitted to hospital privileges. The Tissue Committee at Toronto General, which was set up quite recently, seems to have been established mainly to comply with legal and accreditation requirements. It is argued that the kind of audit that may be necessary in a smaller hospital (where individual practitioners are being "controlled") is inappropriate for a large teaching hospital such as Toronto General, where heads of departments are members of the Medical School and where the Chief Pathologist is himself a professor at the University.¹¹

The hospital is too large for regular meetings of the whole medical staff to be feasible. Instead, the *active* staff are required to meet at least monthly *by departments* during the academic year. At these departmental meetings the professional work of the department is reviewed and clinical cases are presented for discussion. Meetings may be held more frequently if the head of the department sees fit, and staff are required to attend at least three-quarters of them.

The arrangements at the Toronto General Hospital have been described at length chiefly so that they may serve as a "model" (in the technical, not the normative sense) for a discussion of those we found elsewhere.

Scarborough General Hospital

In contrast to Toronto General, the Scarborough General Hospital (a Catholic hospital with about 340 beds) gives the general practitioner a larger place in its organization. The "indoor" staff consists of honorary staff, doctors whose prestige and competence is such as to "enhance the work or reputation of the hospital"; consulting medical staff, who give their services free of charge at the request of a member of the attending specialist staff; and attending specialist staff, all of whom must be certified by, or Fellows of, the Royal College of Physicians and Surgeons of Canada (those who are certificated must "strive" for Fellowship). The "outdoor" staff consists of a general practice staff, who man the general outpatients' service and must be members in good standing of the College of Family Physicians; and a specialist outpatient staff, whose work is confined to one of the Specialist Clinics in the Outpatient Department. General practitioners also may work in

¹¹For a comment on this, see Chapter 10.

these clinics under the direction of members of the specialist staff. The indoor staff and (with one minor exception) the outdoor staff together constitute the active staff of the hospital; and there is, in addition, a courtesy staff, whose members are privileged to admit and treat their private patients in the hospital, but who cannot vote or hold office in the medical staff organization. General practitioners on the outdoor staff are organized in a Department of General Practice, the head of which is always a member of the Medical Advisory Council. The Department runs the General Medical Clinic in the Outpatient Department. Its members are chosen from among general practitioners who have demonstrated "an active interest in and fidelity to the work of the hospital and a willingness and ability to improve professionally".

The Medical Advisory Council consists of all the heads of departments plus representatives of the organized medical staff (which, as we have seen, is also the Scarborough General Hospital Medical Society—i.e., an OMA branch society and local medical academy). The President of the Society (i.e., the President of the Medical Staff) is always chairman of the Medical Advisory Council, whether he is a specialist or a general practitioner. He is also a member of the Board of Trustees. The MAC meets at least monthly. Its committees include the Committee on Credentials (which in this hospital also deals with questions of ethics and discipline), one of whose members must be a general practitioner; an Interne and Education Committee; a Medical Records Committee; and committees on pharmacy control, library and coordination of outpatient work. The Tissue and Audit Committee is composed of the Pathologist, the heads of surgery and gynaecology and obstetrics, and two members chosen by the medical staff. Every tissue is examined in the Pathologist's Department and any cases he questions come to the committee. Typical of such cases are those where there is a difference between pre- and post-operative diagnosis or between the pre-operative and the pathological findings; all cases of hysterectomy where the woman is of child-bearing age; and cases of post-operative infection. (This would appear to be the normal pattern of Tissue Committee activity in the larger hospital.)

Our inquiries suggest that in this hospital relations between general practitioners and specialists are good, and (as one informant put it) the general practitioner "does not feel obliged to fight for his privileges". In practice, a general practitioner who is given privileges has full privileges in the medical, obstetric and emergency departments, and he can even do minor surgery if this is merited by his qualifications (we were told that most M.D.'s would be allowed to deal with minor, straightforward fractures and the lancing of abscesses and boils, but they would not, for example, be allowed to do a curettage or to remove tonsils). Undoubtedly one of the reasons for the closeness of this liaison at Scarborough General is the organization of the Outpatient Department. This hospital has no internes, and to meet the need for coverage in the department at off-times a general practitioner rota system was devised. This means that one general practitioner is always on duty — physically in the department — for an eight-hour period during which he closes

his office. There is also a rota for general surgeons, so that one is always available somewhere in the hospital; and other specialists are, in rotation, on call at home (they need not be in the hospital but must be free and ready to come if called). It was suggested to us that this system not only enables the hospital to meet the serious "Emergency Room problem" noted earlier; it also gives a major place in the hospital to the general practitioner, at least in the sense that it is he who first sees the patient, gives him treatment, assesses his condition and decides on his disposal.

Toronto East General Hospital

Our third hospital in the Toronto area was the Toronto East General, a unit of about 600 beds. The Medical Staff By-Laws have been recently revised following a recommendation by the Canadian Council on Hospital Accreditation in 1965. There are (as might be expected) many similarities between its medical staff organization and that of the Toronto General Hospital. We shall not dwell on these. There are, however, some differences. The staff is divided into consulting, active, Department of General Practice, clinical assistant, courtesy and temporary. The active staff is composed of specialists (certified or Fellows) who form the core of the hospital staff. The consulting staff are retired members of the active staff; clinical assistants are specialists appointed to the Outpatient Service; and the courtesy staff consists of general practitioners not in the Department of General Practice and some private practice specialists with access to the hospital. The Department of General Practice is merely a device for grouping (for administrative and educational purposes) the general practitioners with in-hospital privileges. The head of this department has a seat on the Medical Advisory Committee; but the members work in the Outpatient Department under the supervision of members of the appropriate clinical departments of the hospital, or in the Department of Obstetrics and Gynaecology under the head of that department.

Retirement from the active staff is at age sixty-five, with termination of hospital privileges for everyone at age seventy. We were told that this has been an extremely contentious issue, necessitating a decision by ballot.

The Chief of Staff (who is appointed annually by the governors of the hospital on the advice of the Medical Advisory Committee and may not serve for more than five years) is chairman of that committee and a member of the Board of Governors. We asked the present incumbent about relations between the medical staff and the governors. He identified four main channels of communication. First, the President of the medical staff (as well as himself) is a member of the Board of Governors. The President is elected by the staff and represents them. The Chief of Staff is the official liaison between the governors and the Medical Advisory Committee. Second, the minutes of the MAC are received at Board meetings and the Chief of Staff may speak to them at the meeting. Third, there is a Joint Conference Committee consisting of representatives of both governors and staff: this meets approximately quarterly (more often

if required) to discuss matters of mutual concern. In the past year, we were told, it has been mainly occupied with the building program. Fourth, the Administrator represents the Board at medical staff meetings. These arrangements (or very similar ones) seem to be usual in the larger hospitals.

The Medical Advisory Committee consists of the heads of departments, one head of a division or a service within a department designated annually by the Committee (presumably in rotation), the Administrator, the Medical Director and two members chosen by the staff at the annual meeting. Because of the size of the MAC there is an Executive Committee which meets over lunch each month to discuss the agenda for the next meeting of the full Committee. This consists of the Chief of Staff, the President of the medical staff, the chiefs of two departments in annual rotation, the Administrator and the Medical Director. The recommendations of this body are usually accepted by the full Committee.

The Medical Director apparently plays an important role in the process of "quality control", although there is a four-member Tissue and Audit Committee and a Chart Committee and very detailed records are kept. The Medical Director describes himself as a listening post. He may, for example, hear through the nursing staff that a particular doctor is not attending his patients regularly; he may get information through his contacts with internes and residents, or by virtue of the fact that he is a member of every standing committee in the hospital.

Other committees include the Utilization (of facilities) Committee, which reviews admissions procedures and related matters; the Interne Committee; the Pharmacy and Therapeutics Committee; and the Library Committee. There is also a Committee on Therapeutic Abortions, and no abortion may be performed without its consent. Finally, a Planning Committee makes recommendations on the long-range development of the hospital's facilities.

According to the By-Laws, heads of departments and divisions are appointed on the recommendation of the MAC. In fact, applicants for headships are first interviewed by a committee, composed usually of the Chief of Staff, the retiring head of the department and an outside person (frequently a professor of the corresponding specialty in the University of Toronto). It is customary for every member of the department to be interviewed, and the committee's recommendation is generally accepted.

Parry Sound General Hospital

Let us now consider a much smaller hospital. The Parry Sound General Hospital is located in a small town in a beautiful summer vacation centre about 150 miles north of Toronto. The hospital, which has approximately 130 beds, serves a large surrounding area; and, because of the nature of the area, much heavier demands are made on the hospital in summertime, when there is a large influx of tourists, than in the winter months.

There are three main categories of staff: consulting (both specialists and general practitioners), who are either active consultants or honorary consultants; and associates. Active consultants are those who are "regularly active in the care of patients in the hospital", honorary consultants are those who may "occasionally be called in" and associates are active staff on probation. All applicants for membership in the medical staff must be "professionally qualified for membership in the local medical society". Only the active staff are entitled to vote and hold office in the medical staff.

All applications to join the medical staff go first to the Credentials Committee, then to the Medical Advisory Committee, and then to a Medical Staff meeting which in turn recommends acceptance or rejection to the trustees. Heads of departments are appointed in the same way and must be chosen from among the active staff of the hospital. There is a Chief of Staff appointed by the trustees on the recommendation of the medical staff.

In fact, the situation is even more "democratic" than the By-Laws would suggest. There are only fifteen doctors on the medical staff and most are general practitioners.¹² In common with the practice in many of the smaller hospitals we examined, all doctors on the staff of the Parry Sound General Hospital are expected to share in medical staff duties by means of a rotation system. A typical four-year progression would be from Secretary of the medical staff, to Vice-President, to President and finally to Chief of Staff. Medical staff duties can become a burden, especially in a small hospital, which lacks the bureaucratic superstructure of a bigger one; and no one who has clinical responsibilities will undertake them lightly. The rotation system is a way of spreading the burden equitably, and it also gives everyone a chance to share in medical staff-Board of Trustee relations. The situation is similar at Oshawa General Hospital, although this is a much larger hospital of about 540 beds, where "this" year's Chief of Staff is "last" year's President of the medical staff, "this" year's President is "last" year's Vice-President, and so on through the ranks of the office-holders. A further reason for the practice of rotation suggested to us at this hospital is linked to the question of hospital discipline: namely, that an office-holder who is a specialist depending on referrals is placed in a difficult position (particularly when holding the office of Chief of Staff) since he is responsible to the Board for disciplining doctors in the hospital, and is thus reluctant to hold the position for any longer than he can help.

The burden of medical staff duties is a frequent complaint, and it is interesting to note that this was taken up in a recent report by a Special Committee of the Sudbury Medical Society which was set up to study the medical needs of the community. There are three hospitals in Sudbury and each of them has a Medical Advisory Committee, Tissue and Audit Committee, Credentials Committee, and

¹²Virtually all the physicians in Parry Sound belong to one of two clinics.

so on. It was estimated that, together with other necessary but non-mandatory committees, there are between thirty-eight and fifty-five committee positions to be filled each year in each hospital. In addition there are quarterly meetings of the medical staff to attend and meetings of the local medical society itself. The report suggested that this workload was arousing increasing resentment and that one partial solution was to amalgamate the Tissue and Audit, Medical Record and Credentials Committees of the three hospitals and certain others (Infection, Pharmacy, Education and Library). By this means it was hoped to reduce the workload by about 30 per cent.

Parry Sound General Hospital is small enough for staff-trustee relations to be highly informal, and it was suggested that no policy goes into effect until the medical staff has approved it. At the time of writing, the Board included a lawyer, two high-school teachers, a businessman, a railroad worker, the President of the Women's Auxiliary of the hospital, a representative of the visiting clergy at the hospital, a representative of the Town Council, and three doctors — the Chief of Staff of the hospital, and the President and Vice-President of the medical staff. There is an important point of principle here. Under Regulation 523 only in Group A hospitals may the Medical Advisory Committee be directly appointed; in all other hospitals "The Board (of Trustees) shall pass by-laws that provide for . . . the election by the medical staff of a medical advisory committee for recommendation to the board for appointment".¹³ It would appear that the OHA and the OHSC have taken the view that the medical staff should be "what the Board of Trustees wants it to be". The OHA's position, in particular, is that

. . . by making the election process mandatory the Act could have the effect of preventing a hospital board from having a voice in choosing its own advisors on medical matters.¹⁴

The OMA, on the other hand, has proposed that *greater* powers be given to medical staff. Parry Sound is one of those hospitals that have aligned themselves with the OMA's position in opposition to the OHA; and we were informed that this stand was not only acceptable to the Parry Sound Trustees, but that they had actually taken the lead in proposing it. It would seem clear, in this matter as in some others, that a too rigid application to small hospitals of criteria that are appropriate for larger and more highly organized ones not only is likely to be ignored, but may actually do harm by disturbing existing relationships. On the other hand, it cannot be denied that there is a possible danger of undue medical dominance.¹⁵ At Parry Sound Hospital the representatives of the Medical Staff who sit on the Board of Trustees (i.e., the President and Vice-President and the Chief of Staff) currently sit also on the following committees of the Board of Trustees: the

¹³Regulation 523, Section 6 (1) (c).

¹⁴*For Your Information*, Bulletin from the OHA, December 21, 1966.

¹⁵It is not suggested, of course, that these dangers are realized at the Parry Sound General Hospital.

Management Committee, the Finance Committee, the Property Committee and the Public Relations Committee; and on the Planning and Development Committee there are three non-office-holding members of the active medical staff.

Saint Mary's-of-the-Lake Hospital

We shall now look briefly at Saint Mary's-of-the-Lake Hospital in Kingston: a 200-bed hospital for the chronic sick which is run by a religious order. This hospital is likely untypical of its kind for, after a long period of negotiation, it has recently become affiliated with the Medical School of Queen's University. Appointments to the staff are made in the usual manner (that is, annually by the Board of Trustees on the recommendation of the Medical Advisory Committee), though there will in future be some joint appointments with the University. Included in the terms of the agreement with Queen's is a provision for a University-Hospital Joint Liaison Committee. St. Mary's has long provided instruction for medical students and nurses at Queen's: the agreement signifies a new departure in rehabilitative medicine, but for the present the teaching unit for this purpose will be confined to twelve beds.

Leaving aside the University appointments, there are three categories of staff at St. Mary's. General practitioners have courtesy staff privileges, which allow them to attend their private patients in the hospital (there were about twenty G.P.'s on this staff at the time of writing). As such they have no right to vote or hold office in the medical staff organization. The other categories are the attending staff (at present four doctors with little turnover of membership: an internist, a general surgeon and two general practitioners with a special interest in the chronic sick) and the consultant staff (which may, and usually does, consist of professors of the Faculty of Medicine at Queen's and some emeritus professors). Both these categories have admitting rights.

In such circumstances the framework required by law obviously must be operated with a maximum of informality, and this is indeed the case. The general practitioners are invited to attend staff meetings but rarely accept. The Medical Advisory Committee consists of the President and Secretary of the staff, the Sister Administrator, and two representatives of the trustees. Before the recent revision of the By-Laws all four members of the staff were on the Medical Advisory Committee. Offices must rotate among these four doctors, for they are the only ones with voting and office-holding rights, and almost all the committee work is done by them.

Women's College Hospital, Toronto

Our final example is the Women's College Hospital in Toronto, a somewhat unique hospital in that men are appointed to the active and associate staffs only when there is no acceptable qualified woman physician available. It has approximately 280 beds and a medical staff of about ninety. There are five main categories

of staff: honorary (or emeritus) staff; consulting staff (specialists in active practice but having no regularly assigned duties in the hospital); active staff, who must have a Fellowship or Certificate in their specialty or be members of the College of Family Physicians of Canada;¹⁶ associate staff, who are probationary, seeking appointment to the active staff; and courtesy staff, who may admit and treat their private patients, subject to the approval of heads of departments or services, in accordance with specifically defined privileges.

The Medical Advisory Committee consists of the heads of departments; the President and Vice-President of the medical staff; the Chairmen of the Records, Tissue and Interne Committees; and up to two elected representatives of the active medical staff.¹⁷ The Credentials Committee, which is both a credentials and a disciplinary committee, advisory to the MAC, consists of all the heads of departments. The Tissue Committee includes the Chairman of the MAC and representatives of the Departments of Medicine, Obstetrics and Gynaecology, Surgery, Anaesthesia, Laboratories and the head of Hospital Health Service. The following extract from the By-Laws is not untypical of a hospital of this kind and size:

Any report of the Tissue Committee questioning the professional work of an individual member of the medical staff shall first be discussed with the Chief of the Department concerned, and then shall be presented to the Chairman of the Medical Advisory Committee, with the identity of the individual concerned withheld, for such investigation and action as may be deemed advisable by the Medical Advisory Committee.

A similar procedure applies to questions that may arise concerning the general professional work of members of the medical staff, except that these are considered by a separate Medical Audit Committee. This committee is charged with conducting a continuous audit of the quality and quantity of professional work performed in each department of the hospital. The membership is similar to that of the Tissue Committee, except that the President of the medical staff (but not the Chairman of the MAC) is a member, and the Departments of General Practice and Radiology are represented.

General Structure of Hospital Organization

Though we examined many more hospitals than have so far been mentioned, sufficient similarities were observed, at least between broad types,¹⁸ to make a further recital tedious and repetitious. In any event, enough has now been said for a brief general "profile" to be presented.

¹⁶This is divided (as at Scarborough General) into active indoor and active outdoor, the latter consisting of general practitioners manning the Department of General Practice and some specialists in the Outpatient Clinics.

¹⁷If neither the President nor Vice-President of the medical staff is head of a department — no elected members; if one of them is — one elected member; if both of them are — two elected members.

¹⁸This, of course, is not very surprising since all the hospitals were accredited and must therefore conform to a certain broad pattern.

In hospitals with 100 beds or more the medical staff must be represented on the Board of Trustees. There is at least a possibility, in a hospital of about this minimum size, and especially when it is in a small community, that the Board of Trustees may be small and "local" enough for the medical staff to exercise undue influence in the running of the hospital. This is less likely to occur in a larger hospital in a bigger community where, of necessity, there will be a sharper differentiation of function between the trustees and the medical staff, and where there will exist a more elaborate administrative superstructure. On the other hand, the influence may work the other way. While this report was being written, the press carried reports of the resignation of the eleven-man Medical Advisory Board of the North Bay hospital. The trustees of this hospital are appointed by the city council and the doctors resigned because, they said, they had lost confidence in the trustees. They said that the trustees were influenced "more by certain individuals than by the unanimous opinion of the Medical Advisory Committee". As a result, the hospital trustees asked the Ontario Hospital Services Commission for a full investigation.

Every hospital must, by law, have a medical advisory committee and a President, Vice-President and Secretary of the medical staff. There are, however, considerable differences in the way these matters are handled, depending (in part) on the type and size of the hospital. In the larger hospitals the medical advisory committee tends to be somewhat divorced from rank-and-file staff opinion and to be dominated by heads of departments and services. Further, in Group A teaching hospitals most of these heads (all those who are heads of *teaching* departments) will be joint appointments with the university and medical school. In all but Group A hospitals the medical staff elects the medical advisory committee; but even here there may well be provision for the heads of departments to be members of the Committee *ex officio* or in rotation, thus restricting the electors' choice — unless, of course, the heads of departments are themselves selected periodically by popular consent. In all hospitals the medical staff elects its officers annually, but in the smaller hospitals (and even in some of the larger, such as Oshawa General) there may be an agreement that the election will be such that, in fact, offices rotate. In the smaller hospitals, the medical staff may be so small that this is unavoidable.

The prime functions of the medical advisory committee, subject to the over-riding authority of the trustees, are (in form at least) to determine who shall be admitted to the hospital staff to do what and under what conditions. For this purpose the staff is usually divided, as we have seen, into categories: for example, active or, sometimes, "attending"; courtesy; associate, and so on;¹⁹ to control the

¹⁹No patient may be admitted to a hospital except on an order of a medical practitioner who is a member of the medical staff of that hospital; and doctors associated with the larger hospitals who are not members of the *active* staff usually have their inpatient-visiting and inpatient-treating privileges closely circumscribed — if, indeed, they have such privileges at all.

There appear to be quite considerable differences in who gets voting rights in the medical staff organization. At Kingston General, for example, members of the associate staff (who have all served a probationary period on the courtesy staff) are granted voting privileges. At Oshawa General only the active staff of the hospital are allowed to vote or hold office.

quality of medical care provided; and to exercise disciplinary control over the staff. Again, there are considerable differences in the manner in which these functions are actually carried out. In the larger hospital the privileges of doctors who are not on the active staff are reviewed by those who are — i.e., those under whose supervision they work. In a teaching hospital the medical staff tends to be, in effect, “closed”: that is to say, admission to hospital privileges is determined not simply by the physician’s competence, but by other factors as well. In such hospitals the question of who gets in to do what is usually decided by heads of departments acting in the name of the medical staff of the hospital but also in the interests of the medical school. In a hospital such as Kingston General, there is a definite tension between the needs of the university medical school (“excellence of patient care” — for the unusual rather than the common ailment — for teaching purposes; the pressure for “teaching beds”; and so forth) and the needs of the hospital considered as a community hospital, where the community has an interest in seeing that their doctors, both specialists and general practitioners, have the right to practise in it. In the larger, non-teaching, non-university-affiliated hospital the medical staff is still to a large extent closed, but for other reasons. In the larger departmentalized hospital, in both matters of privileges and matters of discipline, there tends to be considerable delegation of effective authority to department heads. At the other extreme, in the small hospital the formal functions of the MAC may well be assumed in practice by the active medical staff as a whole.

These matters of admission to hospital privileges, discipline and “quality control” are taken up again later in the section dealing with the regulatory aspects of organized medicine.

Appendix I

Medical Staff Organization in a Small Hospital

The following account, taken directly from the notes of one of our research assistants, will perhaps give the flavour of medical staff organization in the smaller hospital (and, incidentally, of medical practice in a country district).

The local hospital was built in 1960 and has thirty-six beds. The active staff consists of the four local G.P.'s and one surgeon, and two visiting surgeons from neighbouring towns. These seven doctors are the Medical Advisory Committee; they take it in turns to be Chairman. They decide on who shall have hospital privileges (i.e., admitting and visiting) and discipline cases. There is an appeal on discipline to the Board (of Trustees). "We always write in detail to the College (of Physicians and Surgeons of Ontario) on any possible discipline case as we like to work closely with them." They (the seven hospital doctors) seem to rely heavily on the College for information about any new doctor applying for hospital privileges. The applicant has to fill in a form stating his qualifications and what he wants to do. The Chairman of the MAC then writes to the College and to the persons recommending the applicant and the application is considered by the Credentials Committees (two of the seven doctors) and then by the MAC. A G.P. newly qualified would only be allowed to do minor surgery — i.e., lancing boils, tonsils(?), etc. Dr. A (the general practitioner respondent at this interview) says he would be allowed to do anything he wants, but actually he only does minor surgery (tonsils, fractures and — he says — curettage). He also does some anaesthetics for which he has no formal training but has learnt by experience. They have only had to discipline one case since the hospital opened: an anaesthetist whom they discovered inhaling the anaesthetic. He later committed suicide. It is since then that they have made very certain that the College has nothing against a doctor before they allow him hospital privileges.

The Tissue Committee considers every case of tissue removed. Except in minor surgery every tissue removed is sent to a pathologist in _____ (a large nearby town) to see whether there has been any error; i.e., normal tissue removed, or whether the pre-operative diagnosis has been confirmed or if not, the reason for the variation. The Tissue Committee (all doctors at the hospital) meets once a month and studies every report from the pathologist. There is a private laboratory in the hospital but this is only used for blood tests and urine analysis. Dr. A is the liaison officer between the hospital and this laboratory.

There are obviously no difficulties over hospital privileges here (she means, by comparison with hospitals in the larger centres) and Dr. A says this is why

he hopes some of the younger doctors will be attracted to the country districts. At present they are under-doctored. Four doctors are located in _____ district for 12,000 people and one doctor is over seventy. There are three in _____, two in _____ and one in _____ (neighbouring small towns). Dr. A's patients come from as far as fifteen miles from _____ (the town in which he practises), including farmers who ring him up at six a.m. expecting attention before their day begins. His office hours are from two to seven p.m., then he has all his cases to write up, and any visits. He says he does not finish before one a.m.

Chapter 6 The Medical Schools

*Brothers all
In honour, as in one community,
Scholars and gentlemen.
—Wordsworth, The Prelude, IX, 227*

It is scarcely necessary to emphasize the key role of the medical schools in shaping the medical profession, nor the crucial place they occupy in the structure of organized medicine. They take the initial decisions as to who shall be admitted to, and who excluded from, the profession. They socialize as well as train doctors. And the quality of the staffs of faculties of medicine is a vital factor in determining the ultimate quality of medical practice. At this moment, the medical schools are shaping the future of medicine in Canada. Their part in regulating entry to the profession is considered in Chapter 8; their role in medical education and medical research, in Part Four.

Current Enrolment and Distribution

In 1966-1967 there were just over 1,400 full-time medical students in the four Ontario medical schools.¹ A fifth school is under construction at McMaster University in Hamilton; a sixth has been proposed for York University in Toronto or the University of Windsor; and the possibility of a seventh school, serving Northern Ontario and possibly located at Laurentian University, has been mooted. Developments currently under way were predicated on the announcement by Premier John Robarts in 1964 that the province would support the expansion of the four existing schools and the creation of a new one at McMaster. Toronto has planned an expansion which will double the school's output — the equivalent of the construction of a second school in Metropolitan Toronto.

Toronto is the largest medical school in Canada; the other three Ontario schools are exceeded (in terms of numbers enrolled in 1966) only by Alberta, Manitoba, McGill, Montreal and Dalhousie. The enrolment for Canada as a whole in 1966-1967 was 4,230 (i.e., Ontario's share of the national total was exactly one-third).

¹The figures are

Year	I	II	III	IV	Total
Toronto	159	178	182	133	652
Queen's	70	59	60	47	236
Ottawa	78	65	67	52	262
Western Ontario	77	72	56	59	264

Source: Duff and Fish, "Medical Students in Canadian Universities: Report on Statistics 1966-67", *Canadian Medical Association Journal*, Vol. 96, April 1, 1967, p. 921.

Roughly 92 per cent of the total national enrolment were Canadian citizens or landed immigrants; and of the 8 per cent who came from other countries (a total of 340), 148 came from the United States, 165 from Commonwealth countries and only 27 from elsewhere abroad. The number of Americans in Canadian medical schools has fallen quite sharply (from 309 in 1959-1960), whereas the number of students coming from Commonwealth countries has increased (from 126 in 1959-1960).

Women constituted just over 12 per cent of the total Canadian enrolment in 1966-1967, a slight increase on the previous year. In 1965-1966, the last date for which comparable figures are available, women constituted 8.4 per cent of the first year in the United States and 12.8 per cent of the first year in Canada.

In Ontario, in terms of output, Toronto was well in the lead with 157 graduates in 1966. Queen's graduated fifty-eight, Ottawa fifty, and Western Ontario fifty-four. Toronto graduated twenty-six women, Queen's nine, Ottawa five, and Western Ontario seven. It is interesting to note that the number of graduates from all schools in Canada (888) exceeded by thirty-three the MacFarlane Report projection for that year.

There is considerable discussion about the "localization" of input and output, and this has importance for policy. In 1966-1967 over 95 per cent of Toronto's medical students were Ontario residents, 3.5 per cent came from other provinces, about 1 per cent from outside Canada. The comparable proportions for the other schools were: Queen's 89 per cent, 8.5 per cent, and 2.5 per cent; Ottawa² 93.7 per cent, 6.3 per cent, none; and Western Ontario 96.5 per cent, 1.2 per cent, and 2.4 per cent. The Canadian school that drew most heavily on other provinces for its students in 1966-1967 was McGill (18.2 per cent); it was followed by Queen's, Manitoba (7.6 per cent), and Ottawa. Clearly the vast majority of Ontario's medical school students come from within the province; and this is not surprising, given the system of grants (an Ontario grant is not available for the "outsider" in the first year of his residence). Moreover, it is argued that the high cost of a medical education virtually forces the student to live locally and commute if he possibly can.

What about output? Evidence submitted to the Committee on the Healing Arts by the Ontario Medical Association refers to a study made in 1962 of the 1950-1951 cohort.³ Of the first year medical students in Ontario in 1950-1951, ten years later, 27 per cent were practising in the large cities of Ontario (16 per cent in Toronto), 25 per cent were practising elsewhere in Ontario, 25 per cent were practising outside Ontario, and 23 per cent were not licensed to practise in Ontario (this group included drop-outs and failures, and those who had registered

²For the University of Ottawa Medical School, "the province" includes Ontario and Quebec.

³I.e., the group of first year medical students registered in that academic session in Ontario medical schools.

— not merely chosen to practise later — in other provinces). The study indicated that the metropolitan centres contributed about twice as many medical students as the rest of the province, and gave in the form of medical students more than they eventually got back in the form of graduated doctors. If the same factors are still at work, it would appear that by the late 1970's only about half the students entering first year medicine in Ontario medical schools this year will be practising in Ontario.

Evidently, although medical schools may exercise considerable control over the input process (though even this is subject to a number of social factors⁴ that are more or less beyond their control), they have a much weaker influence on the ultimate distribution of the product.

School Accreditation

The medical schools of Ontario (as elsewhere in Canada) enjoy a high degree of autonomy. As we have seen, there is a provision in the Medical Act that empowers the College of Physicians and Surgeons to determine the undergraduate curriculum; but this is impracticable under modern conditions (whatever its historical justification may have been) and is not, in fact, acted upon. The Council of the College exercises a loose kind of watching brief on what the schools are doing, defending it on the ground that too much diversity may be harmful.⁵ Clearly the College has an interest in the education of the medical student, since it is the College that will ultimately grant him a licence to practise; but its role today is hardly more than advisory. Quite recently, for example, the College was asked by the Minister to consider the possibility of shortening the duration of the medical course by reducing vacation periods. This was done (by the College's Education and Registration Committee); and it led to discussions between the Committee and the deans of the Ontario medical schools. The College does specify minimum standards of entry to the medical schools: at present, either senior matriculation in subjects specified by the College, or a degree in arts or science from an approved university or college.

The medical schools are subject to accreditation, not by a Canadian body⁶ but by a visiting team put together by the Association of American Medical Colleges and the Council on Medical Education of the American Medical Association. (Accreditation is actually granted by a Liaison Committee made up of representatives of the two bodies, and this is accepted by the licensing bodies in all the Canadian provinces and by the state boards in all fifty states of the U.S.A.) It is

⁴Discussed in Chapter 8.

⁵The General Medical Council in Britain exercises functions in respect to medical schools that are very similar to those of the College of Physicians and Surgeons in Ontario, but defends them on precisely the opposite ground: namely, that it is its duty to foster diversity and experiment in medical education.

⁶Canadian dental schools are approved by the Council on Dental Education of the Canadian Dental Association (the deans of all the dental schools sit on this Council).

now normal to include in the team one or two representatives from Canadian medical schools selected by the Association of Canadian Medical Colleges, and the Secretary of the team is usually Canadian. Visitations are made at intervals of from seven to ten years and, it is understood, on a change of dean. According to the Dean of the new medical school at McMaster,⁷ the accreditation proceedings there were more concerned with the adequacy of the facilities proposed, and with the quality and availability of teaching staff, than with curricula. In the case of established medical schools, the inspection teams also look at research activity, teaching methods and quality, and the general structure of the degrees awarded.

It may be (and, indeed, has been) asked whether there is not now sufficient accumulated experience to permit a purely Canadian body to assume this function. There are two rather strong practical arguments for continuing the present practice. First, accreditation by "outsiders" is less embarrassing to all concerned, given the still relatively small number of Canadian medical schools and medical school deans (there are eighty-seven in the United States). Second, because of the flow of teachers, students and practitioners between the two countries, it is important to have common minimum standards of acceptability. There is, however, some latent resentment of American "interference" that is not purely chauvinistic. This became apparent when it was made known publicly early in 1966 that four Canadian medical schools had been on "confidential probation" for the past ten years, chiefly on account of inadequate and overworked facilities, insufficient teaching staff, and lack of research of high quality. It has been suggested to us by a highly placed medical administrator that this action (the placing of the schools on probation) might have been avoided — or perhaps one should say evaded — had the accreditation been in Canadian hands. The arguments for and against the status quo are fairly evenly balanced. On the one hand, there is much to be said for "international standards". On the other, there are dangers: the accreditation process, inevitably perhaps, may more easily be used to pressure governments,⁸ and even to support *ex parte* arguments and dissensions within a faculty, when the responsibility for recommendation can be laid on outsiders.⁹ There is a risk that an outside accreditor may not take sufficiently into account the peculiar conditions obtaining in a foreign social milieu because he does not fully understand them. And there is some danger, as Canada moves into an era of greater public responsibility for the provision of medical care, that the growing ideological gap between the medical professions in the two countries may make it harder to reach impartial judgements.

Formal liaison between the Ontario medical schools is maintained in two ways: through the Committee of Presidents of Universities of Ontario, and (more especially) through the regular meetings of the Committee of Deans of Ontario Medical Schools. The interests of the Canadian medical schools as a whole are

⁷Committee on the Healing Arts, Hearings, June 1967.

⁸The "one-third on probation" story was broken to the press in this province by a well-known and highly energetic advocate of massive public aid for medical education and research.

⁹Cf. the role of "the stranger" in sociological literature.

fostered by the Association of Canadian Medical Colleges. This was set up in 1943, was incorporated in 1961, and appointed its first full-time executive secretary in 1962. Governed by a Council, it acts as a link between the medical schools across the continent; attempts to present a common front to the federal government (particularly in relation to the Health Resources Fund) and other public authorities; and it is undertaking an expanding program of research in areas respecting the provision and utilization of medical education where there is, as yet, a dearth of "hard" information. Its activities bring it into close contact with the CMA, the Royal College, the Medical Council of Canada, and the provincial licensing bodies; with the Association of Universities and Colleges of Canada (with which it shares an office building); with the provincial hospital insurance commissions; with the Medical Research Council and other research bodies and foundations; and with the Association of American Medical Colleges and the AMA. Dr. MacDermot has called it "in fact, the only body which can coordinate medical education in Canada";¹⁰ and, as things stand at present, that is largely true.

Recent Changes in Structure

Organizationally, the faculties of medicine have tended to be rather loose federations of basically independent departments, each responsible for an educational and research program related to its specific discipline, with not very closely defined links between the basic sciences departments on campus and the clinical sciences departments centred in the teaching hospitals. The creation of the new Health Sciences complexes is a partial response to these deficiencies, and an acknowledgement of the growing need for greater communication and collaboration over the whole field as medical science progresses.¹¹ They are also an acknowledgement of the ever-growing responsibilities of the medical schools in training for the professions supplementary to medicine: nurses, blood bank technicians, medical laboratory technicians, operating room and radiological technicians, and a host of others, many of whom have related educational needs.

Traditionally, again, the medical schools have concentrated their efforts on undergraduate medical education. They are now moving into an era in which postgraduate and continuing medical education are fast becoming at least as important as, if not more important than, this original function. Indeed, it has been suggested that the provision of specialty training programs in medicine and

¹⁰H. E. MacDermot, *op. cit.*, p. 117.

¹¹To quote from a submission by the Faculty of Medicine of the University of Toronto: "The progress of events in the University of Toronto (in medical research) leads to the inevitable conclusion that the barriers and boundaries of disciplines established a hundred years ago no longer have the validity they once did. Originally the limitations of the disciplines permitted people with similar interests and techniques to work together to advance knowledge in their particular field. There is still room for this type of development but too often in recent years the boundaries of the discipline have become barriers that prevented exchanges of information and collaboration that we know are necessary to the advancement of medical science at this complex stage of its evolution."

the demand for continuing education for the practising physician already impose on medical faculties a teaching responsibility which *exceeds* the time devoted to undergraduates.¹²

Relations with the teaching hospitals also are undergoing change. It is only quite recently, for example, that research has become really important in the clinical departments of the medical schools. In the past, Canada has tended to follow the historic British pattern of appointing as members of staff, including heads of departments, doctors who were outstanding teachers and practising clinicians rather than men strongly motivated or sympathetic towards scientific research. This is now changing in Britain with the rise of the provincial medical schools (after the National Health Service Act); though in London the traditional pre-eminence of the part-time consultant Establishment has been breached only by creating separate postgraduate schools and London University-financed "professorial units" within the twelve consultant-dominated and primarily undergraduate-teaching-oriented hospital medical schools. Canadian medical schools, it is said, now feel impelled to move nearer to the American pattern, to keep their standards in line and to allow their staffs to hold their own in the American learned societies to which so many of them belong.¹³

We have already noted the growing tension between the interests of the medical schools and those of (at least some of) the teaching hospitals. This manifests itself most dramatically, perhaps, in disputes over the allocation of beds for clinical teaching, due in part to the virtual disappearance of the indigent patient; and it has come to a head, in at least one centre, in the process of planning the new Health Sciences Complex. There is a tendency for medical school administrators to opt for the university teaching hospital, partly because the teaching need for "exemplary patient care" does not always square with the other functions of the affiliated community or regional-centre hospital, and partly because a university hospital is under the sole control of the medical faculty.

The University of Toronto has recently acquired Sunnybrook (a former DVA hospital); Western Ontario has its own hospital; McMaster is building one; and there has been discussion about Queen's and Ottawa doing the same.

¹²*The Health Services in Ontario*, Report of the President's Research Committee to the Committee of Presidents of Universities of Ontario, June 1966, p. 3.

¹³It should not be assumed, however, that all American physicians are happy about their own institutions. Dr. John Knowles, Director of the Massachusetts General Hospital (a Harvard Medical School affiliate) has put the matter succinctly: "The medical students are complaining that the professors are no longer professing. 'Why,' they ask, 'can't they teach us medicine?' The answer is that they have abdicated the responsibility of teaching and proper patient care to concentrate on research When you have a clinical department of a medical school headed by a research man—which is typical—what the heck have you got? A sad situation." (Quoted by Martin Gross, *The Doctors*, Random House, New York, 1966, at p. 369.) Gross's later comment, that "the clinical curriculum—basically Osler's 'learning by the hospital bedside'—has obviously been adversely affected by the new research stress", must surely rank as a masterly understatement. It also needs to be pondered in the light of the patently crude, "pragmatic" and hit and miss state of much contemporary medical research. These matters are considered more fully later.

Chapter 7 The Medical Profession in Ontario: Structure and Influence

*But now are they many members,
yet but one body.*

—1 Corinthians, 12: 19-20

The changes in the structure and organization of medicine that we traced in Chapter 1 have inevitably affected the network of influence and power in the profession. Among the most important of these changes are the shift in the balance between the general practitioner and the specialist, the rising importance of hospital-based medical care, and the generally increased "bureaucratization" of the profession. Other factors are perhaps more speculative in their effects. For example, has increasing urbanization and concentration of doctors in the larger metropolitan areas made it easier or more difficult for them to be organized for collective action?

In this chapter, which is in a sense a summary of what has been said so far about organization and structure, we shall discuss the influence of the profession on the professional life of the doctor, the pattern of influence within the medical associations (the "internal politics of medicine") and (more briefly still, since this is taken up again in the last chapter of this report) the external politics of medicine: its relations with government and with other groups.

Professional Life of the Doctor

The pattern of influence on the personal professional life of the doctor is enormously complex. As we have seen, the medical schools exert great pressure in the formative stages of the doctor's career and, to some extent, through the operation of the "old boy" or "old school tie" network, in later stages also. The teaching hospitals are similarly influential. As we shall see later (Chapter 12) more than half the residencies in Canada are in 14 per cent of the approved hospitals, and 65 per cent of all residents in Canada are in teaching hospitals. In 1965, seven of these contained one-third of all the residents in the country. Therefore great influence is wielded by a relatively small number of heads of teaching departments, all of whom hold joint university appointments. These men are important figures in the Royal College. Moreover, the standard pattern of part-time medical school teaching in Canada encourages large numbers of residents working for their Fellowships to aspire to private practice combined with a part-time academic appointment. Many of them, of course, fail to make

it; but the point is that there is a hierarchy of prestigious departments in prestigious hospitals linked to prestigious departments in prestigious faculties of medicine. The deans of medicine (linked through the Association of Medical Colleges of Canada and their own less formal arrangements — in Ontario, the Committee of Deans of Medical Schools) are great men; leading teachers, researchers and practitioners in the medical schools and hospitals are important members of the professional elite; and there are further links through Boards of Examiners of the examining bodies — the Medical Council of Canada and the Royal College.

The College of Physicians and Surgeons of Ontario is an ever-present (though background) influence on the professional life of the doctor; for it is the College that gives, and the College that can take away, his licence to practise — that is, his livelihood. For many doctors the Medical Staff organization of the hospital, a regulatory and even quasi-disciplinary body, holds comparable power. Nor, in considering the context within which the doctor does his daily work, must we overlook the importance of the OMA which determines his fees (or at any rate their general limits) and commits him to courses of action of which, as an individual, he may not wholly approve. Finally, whether the doctor belongs to it or not, the local academy of medicine may well exert considerable social pressure on him as a member of the local medical community.

The doctor embarking on a professional career is heavily dependent on his peers. If he is setting up in private practice, whether as a specialist or a family doctor, he has to acquire a clientele and establish a reputation with his colleagues; and, in his behaviour, he must win the social and professional approval of other doctors. Traditionally, acquiring a clientele was a laborious process, especially for the young general practitioner. He had to spend time working for other doctors, do industrial medicine, practise anaesthesiology for local dentists, take emergency calls, handle other doctors' "cast-off" patients, until he had built up a practice sufficient to live on. The shortage of doctors is changing this picture, and in many Ontario towns the young doctor has little trouble in acquiring patients once he advertises the opening of an office. The young specialist, on the other hand, was, and probably still is, heavily dependent on his older colleagues or those that are already established: for example, on his former medical student friends now in general practice for referrals, on established doctors on the medical staff of a hospital for admission to the probationary staff. Some young specialists get discouraged, and this may account for some at least of those who practise a form of "limited general practice" such as internist or paediatrician (see Chapter 12). All in all, the medical profession is heavily dependent on "goodwill": the goodwill of patients and of one doctor to others. And in Britain, of course, in pre-National Health Service days, the "goodwill" of the practice was bought and sold: it was recognized as a tangible commodity.

We have had neither the time nor the competence to trace fully the fascinating ramifications of medicine as a social system, but there are a number of clues

and hints scattered throughout this report. One thing is clear. There undoubtedly exists, as Professor Oswald Hall has suggested,

. . . a sort of organization which functions to provide order, to ascribe and maintain status, to control the conduct of the members, and to minimize competition and conflict. In other words . . . an orderly manner of incorporating new members into their community, of repelling the unwanted and the intruder, of allocating rights and privileges, of distributing clients among colleagues, of applying sanctions and penalties, and preserving their status.¹

An extremely interesting study could be made — in principle, at least — of the misfit in medicine, and what happens to him. There are many clues. For example, although it is quite impossible to document this without much further research, it is our impression that a rather high proportion of the discipline cases coming before the College of Physicians and Surgeons are physicians from minority ethnic groups. It might be illuminating to find out why.

Internal Politics of Medicine

Much of the group life of the medical profession is expressed through organizations described in the preceding chapters. The key people in official positions in these organizations constitute, by definition, an elite. It is the purpose of this section to outline some of its characteristics.

Sociologists and political scientists who study elites — whether nationally, or at the level of the local community, or in interorganizational contexts (such as “power in the business community”) — usually end by finding what they are looking for. If, for example, they proceed by what is sometimes called the “reputational” method — by asking people to identify “who really runs this town” (or whatever it may be) — they tend to come up with a rather small group of people “who wield power”, who “make all the key decisions”, and so on. If, on the other hand, they begin by tracing out the interconnections between the leaders of the various organizations and groups — family ties, social connections — they are more likely to conclude that “things are run” by an Establishment held together by common values and outlook based on similarities of education, social class, tradition, and so on. If, again, they start by looking at the key figures in the making of a specific set of decisions, they arrive at the conclusion that different sets of people exercise varying amounts of power and influence in different situations — that is, they conclude, generally speaking, that there is not one elite but many; and that “things get done”, on the broad scale, through a pluralistic system of competing, bargaining and negotiating groups. On this view, “who really runs this town?” cannot be answered by a simple “X and Y do”. The answer must be “you must first tell me what aspect of ‘running this town’ you are talking about”.

¹O. Hall, “The Informal Organization of the Medical Profession”, *op. cit.*, p. 32.

As we have not made a systematic study of the Ontario medical elite, it must be understood that anything said here is highly tentative. There is, first of all, a certain amount of mythology; and the response you get to "reputational" questions depends in large measures on whom you are talking to. For example, some people suggest that the overt political activity of organized medicine (such as the activities of the OMA) is simply a "front" for a hidden group — key specialists, deans, leading figures in medical school teaching and research — "who really pull the strings on which the OMA puppets dance". (In fact, if one must have a "conspiracy theory", this is probably a shade nearer the truth than the notion that "the OMA runs the show".) Others again have told us that the power in medicine is the Royal College. It controls the specialists, and the specialists control medicine. Yet others say, "In Ontario, it is the chaps on the College of Physicians and Surgeons — the little group in Toronto". On the other hand (and this is a point in favour of the "polyarchal" pluralist approach), the response depends in some measure on the organizational context in which the question is asked, and on the position the respondent occupies in the professional network (whether he is a general practitioner or a specialist, whether he is a member of a hospital staff, and so on).

We have already noted that there is much cross-membership in the profession: that is to say, there is a group — a rather large group — of doctors who wear a variety of organizational hats. This comes about in various ways. In the first place, one of the reasons for the multiplicity of cross-membership links is that this is provided for in the constitutions of the major associations. We have mentioned the links between the OMA and the CMA. For example, the Executive Committee of the CMA includes, in practice, members of the OMA Executive Committee. Second, there is a good deal of deliberate choice. For example, many permanent officials sit on many different bodies because they are the obvious people to choose. If the idea is to secure some measure of liaison, then the permanent officials are likely to be in the best position to represent their own association: they have the time, and they have a broad "overview" of their association's affairs. Third, much of the cross-membership comes about simply because Dr. A is available: he is active in the affairs of his own association, and he is willing to represent it on the committees and boards of others. Fourth, and related to this, membership in some organizations is dependent on membership in others (at least in principle), and those who are most active in one will likely (though not necessarily) be active in another. For example, membership in the various specialist societies is technically dependent on membership in the CMA (though we were told that this "rule" is not rigidly enforced). We have noted that the College of Family Physicians encourages its members to join the CMA, and most of them do (through their membership in the provincial medical associations such as the OMA). Some hospitals insist on membership in the appropriate specialist association for their staff, or in the College of Family Physicians in the case of general practice departments.

Cross-membership operates on at least three levels: between the various medical bodies; between these doctors' organizations and bodies representative of the related health professions; and between the medical organizations and layman-oriented associations (for example, the so-called "medico-lay" associations, such as the Canadian Arthritis and Rheumatism Society;² and, importantly, the lay Boards of Trustees of the hospitals). These links between layman and doctor may well be important for the social scientist who is attempting to assess the centres of influence in the medico-political process. It is clear that if we are considering the channels through which pressures for change in, say, medical educational policy are brought to bear, certain key laymen may play as great a role as medical men. Or, to give another example, decisions in relation to medical staff organization in the hospital (such as, a proposal to revise hospital staff by-laws) are certainly not solely the concern of doctors. The Ontario Hospital Association leadership has a stake in the outcome: and similarly there exists medical representation in the key committees of the OHA and a formal liaison between the OMA and the OHA.

Given these links and the various kinds of cross-membership, it may be worthwhile, even at the risk of some repetition, to review briefly the total picture.

The linkages between the OMA and the CMA are extensive, a fact which is not surprising, given that the two memberships are virtually identical. Moreover, the federal nature of the CMA means, inevitably, that the various provincial associations ("Divisions") must be well represented in all its activities. However, OMA leaders do not necessarily hold the CMA leadership positions occupied by Ontario doctors. In a scrutiny of office holders in 1966, we found that some OMA leaders were also CMA leaders, but other Ontario doctors in CMA leadership positions³ did not hold and had not held high office or even committee positions in the OMA. It must be remembered, however, that many of the CMA committees are specialized committees on which one would expect to find people with a special expertise and/or interest in the subject matter rather than the more professional "medical politician". On the other hand, some committees are deliberately structured to represent their Divisions by people who are concerned with the same matter at the Divisional level. It is not very surprising to find, for example, that in 1966 the Ontario representative on the CMA Committee on Economics was the Chairman of the OMA Committee on Economics and Medical Practice; or that the Ontario representative on the CMA Ethics Committee

²The Executive Director of this body is a member of the Ontario legislature and a prominent advocate of medical research. Though he is a layman, it could be argued that he has a claim to be considered a member of the medical elite. This illustrates rather well the problem of defining the elite which was raised earlier in this chapter.

³Defining "leadership" positions to include seats on committees. "High office-holders" in the OMA sometimes cease to be active in the OMA on taking high office in the CMA. The two careers are not by any means always parallel. One former distinguished OMA leader told us that he "was kicked upstairs" (i.e., into the CMA) because of disagreements with his OMA colleagues on policy.

was the Chairman of the OMA Committee on Ethics. The personnel of some corresponding committees, on the other hand, were quite different.

There are a small number of individuals who are extremely active at both levels, and sometimes in the College of Physicians and Surgeons as well. But, on the whole, cross-membership between OMA and CMA committees, where it occurs, is a matter of deliberate policy resulting from the federal nature of the CMA.

There are also many links, usually rather formal, between the OMA and the related health professions. Perhaps the major link currently is the representative that the OMA shares with the College on the Ontario Council of Health. The first appointee certainly belongs to this small group. Dr. Ian Macdonald represents the University of Toronto on the College; he was President of the College in 1966-1967; he has served on the joint liaison committee of the College and the OMA, was the representative of the University on the Medical Council of Canada, has been a member of the Education Committee of the OMA and has held numerous other "cross-positions". The OMA is represented on the Ontario Board of Radiological Technicians, the Advisory Committees on Radiotherapy and Physiotherapy of the OHSC, the Ontario Welfare Council, the Medical Advisory Committee of the Ontario Cancer Research Foundation, the Institute for Nursing Home Care, the Scientific Advisory Committee of the Canadian Mental Health Association (Ontario Division), the Ontario Heart Foundation, and many others. It also has a liaison committee with the OHSC and the OHA, and another with the OHA, the RNAO and the Ontario Public Health Association.

We have noted that the OMA played a part in the creation of the College of Family Physicians. The links between the two bodies now seem to be somewhat tenuous, although the President of the College in 1966 was active in both organizations. The links with the CMA, however, are close: the Executive Director of the College has a seat on the CMA junior internship approval committee, is Chairman of the special committee on Professional Self-Discipline, and has a seat on the liaison committee with the drug manufacturers. The College of Family Physicians is represented also on the Executive Council of the Association of Medical Colleges of Canada, and on several special committees of the Medical Council of Canada. Some thirty or more medical directors of drug firms are members of the College, and there are meetings about twice a year with the Medical Section of the Pharmaceutical Manufacturers Association. In addition, the College is represented on the Council of the Canadian Mental Health Association.

We have referred to the state of relations between the local academies of medicine, and the OMA and the College of Family Physicians. There is overlapping in office-holding between the College and the local academies, but no formal arrangement for representation. In the case of the OMA, a large part of the General Council consists of delegates from the local societies; but in spite of this,

liaison between OMA headquarters and the branch societies *as such* does not appear to be very good. In its report to Council for May 1966, the OMA Board of Directors said:

Over the years we have attempted to establish closer liaison between members of the Board, the Executive Committee and the Secretariat with (sic) the Branch Societies. Contact has been too infrequent but when it has occurred it has generally proved satisfactory to the parties involved . . . invitations have been few. The Board has agreed that we should take the initiative — i.e., invite ourselves! . . . We are encouraged that such an approach should prove useful because it did *in the case of visits to hospital medical staffs*. (Emphasis added.)

The links between the specialist associations and the OMA are secured, importantly, through the OMA Sections. We have noted that, under its constitution, Ontario specialists make up a quarter of the total membership of the Council of the Royal College of Physicians and Surgeons of Canada; and that there are many links back from the Royal College to, for example, the medical schools and the world of teaching, research and practice, through the College's advisory committees in each of the major specialties.

At various points in this report we refer to the relations between the medical schools and the affiliated hospitals. There is cross-membership between staffs of both because there are many joint appointments. But the consensus is that the relationship is often an uneasy one, and that the doctors who have responsibilities in both are subject to many cross-pressures and conflicting loyalties. The hospital-medical school-university nexus is, in fact, an excellent illustration of the fact that, because people happen to be members of two or more different organizations, it does not follow that a greater concentration of power or influence will result. Many studies of cross-memberships (through interlocking directorates) in the business world have foundered on the fallacious assumption that *merely* to trace out a pattern of connections is to demonstrate that a coalition of interests exists. This is not always the case (though it may be so). In any event, it cannot be shown simply by counting the number of different hats worn by Messrs. X, Y and Z. The same is true of family and social connections. The basic cause of cross-pressure in the case of the medical school and the affiliated hospital is, as we have said, that the former is oriented towards teaching and research, whereas the latter is concerned primarily with service — to deliver health care. This is one reason why medical school administrators tend to favour building their own teaching hospitals, though it would require further research into the actual operation of existing university hospitals to test whether their expectations are really justified — or, at least, to what extent they are justified. This nexus of affiliated hospital-medical school also raises interesting problems about the relationship between medical men and laymen on the Boards of Trustees, though this is general to all hospitals that have members of the medical staff on their Boards. It could be that, in some instances, there is too little rather than too much cross-membership in the governing councils of the two

bodies. On the other hand, the lay trustees may sometimes feel themselves to be caught between the upper and the nether millstones of pressure from government agencies such as the OHSC, on the one hand, and organizations of medical men, both within and outside the hospital, on the other.

Finally, in this brief review, there is the question of the relations between the College of Physicians and Surgeons and the other professional bodies. In various parts of this report, we shall see how the College has been attempting to assert a certain ascendancy in respect to discipline over the medical staffs of the hospitals. There are no formal links: the fact that some members of the College Council are members of a hospital staff is, in this sense, fortuitous. The relations are those of normal diplomacy and attempts at persuasion. On the other hand, the College has many formal links with other organizations. There is the Joint Liaison Committee with the OMA, which on some matters is an important body for reconciling differences. The OMA General Secretary can attend meetings of the College Council, while the Registrar of the College attends Council Meetings of the OMA. The medical schools, as we have noted, have seats on the College Council, in virtue of the College's statutory responsibility for overseeing medical education. The College is represented on the Medical Council of Canada, though not directly on the governing body of the Royal College. Its representation on the Senate of the University of Toronto seems a curious historical anomaly, since it is not represented in the other medical schools. The College has its eyes and ears in various other places as well, often through the presence of the Registrar as an observer at meetings.

It appears (to us at least) to be impossible to give a simple answer to the question "Who runs Ontario medicine"? Since it would have been our interest (had time allowed) to try to trace out the ramifications of the decision-making process in Ontario medical politics, both internal and external, it is perhaps not unnatural that we should adhere to a polyarchal, bargaining, pluralistic viewpoint. It seems to us that the question must be countered by the further question: "Who runs *what* in Ontario medicine?"

This is not to deny that an inquiry into the decision-making process would reveal a pattern of influence exercised by certain key individuals: rather, as we moved about from one decision area to another, we would find that the key individuals *are not always the same people*. Indeed, our impression is that it would be hard to find a single individual whose name would recur in every context, or even in the majority of cases that we chose, assuming the choice to be a random one. For example, there is unquestionably a College-medical school-specialist oriented axis which exercises great influence in certain directions, such as in licensing policy and in policy relating to medical education requirements for full licence. In the stratification system of the medical profession, academic affiliation (going to the "right" medical school), specialty (being a surgeon rather than an internist and a brain surgeon rather than a general surgeon), seniority

(the medical profession is highly "deferential") and even mere "maleness"⁴ count for a lot; but they do not count for everything. And to say, as one of our respondents did, that the medical establishment consists of "an inbred group of doctors educated at the University of Toronto, now teaching there, and practising on the staff of the Toronto General" is a gross oversimplification; though, *within the context in which he was thinking*, and which it is judicious not to specify exactly, he may be right. The structure of the profession — of which the Ontario profession is an interconnected part (and this is said with emphasis) — is too complex to make such simplistic generalizations. Though specialists are generally more prestigious than general practitioners, it does not follow that because a medical politician is a G.P. he will have less influence than another who is a specialist: it depends on the context in which he operates. And some of the medical organizations make a more or less deliberate effort to redress any built-in bias.

External Relations

The argument has even more force when we turn from the internal politics of the medical profession to its external behaviour; or more accurately, from the political behaviour of the profession in regard to its own internal relations to its behaviour in regard to the "outside" world of government and society. Here medicine clearly is not monolithic but a congeries of competing groups; or again more accurately, of groups which may combine in face of external threat or for strategic or tactical reasons, but may equally well compete when their own subgroup interests are specifically involved.

In a paper, "Professions in Process",⁵ Bucher and Strauss criticize the notion of a profession as a relatively homogeneous community: in their view professions are better and more accurately regarded as "loose amalgamations of segments pursuing different objectives in different manners and more or less delicately held together under a common name at a particular period in history". The most significant, perhaps, of the segments in the medical profession are the specialties which separate out from the general stream of medicine and provide self-conscious groups with a special sense of identity. As time goes on the specialties become themselves segmented into subspecialties — for example, diagnostic and therapeutic radiology. Medicine thus becomes segmented in its "sense of mission".

It is segmented also in respect to its work activity: specialist, general practitioner, "near" general practitioner (i.e., paediatrician, or internist, or surgeon doing much general practice work besides); private practitioner, academic doctor, industrial doctor; doctor in solo practice, doctor in group practice; hospital staff

⁴For example, women doctors tend to be found in the less prestigious specialties — and, indeed, in the less prestigious jobs.

⁵R. Bucher and A. Strauss, "Professions in Process", *American Journal of Sociology*, Vol. 66, 1961, p. 325.

doctor, doctor without staff appointment; country practitioner, urban practitioner; specialist whose specialty involves dealing face-to-face with patients, specialist whose work does not (such as radiologist, pathologist) — there is an almost endless range of polar types and combinations. There are differences in the methodology and techniques the groups utilize in their work; there are differences in their clientele:

We suspect that sociologists may too readily accept statements glorifying "the doctor-patient relationship" made by segments of the medical profession who have an interest in maintaining a particular relationship to patients. In actuality, the relationships between the physicians and their patients are highly varied. It does appear that an image of a doctor-patient relationship pervades the entire medical profession, but it is an image which, if it fits any group of physicians in its totality, comes closest to being the model for the general practitioner.⁶

Thus paediatricians see their role as that of doctor to sick child plus parents in the total home environment (i.e., their "patient" is a group of people); whereas the surgeon sees only a "case" of dislocation of the hip (for example) — it is doubtful whether he even sees a whole patient.

Since there is a wide difference of professional interest and work organization, motivation and the like, it is more than probable that these differences will be expressed in different attitudes when it comes to internal and external relations between groups. Medicine is full of conflicts of interest at all levels: *between* organized groups (such as academic doctors and practitioners — though since many doctors are both, there may be internalized conflicts as well); *within* organized groups (for example, between specialisms within the medical school). The impact of this conflict on the layman is not always evident.

The outsider coming into contact with the profession tends to encounter the results of the inner group's efforts; he does not necessarily become aware of the inner circle or the power struggles behind the unified front.⁷

The implication is that there *is* an inner group or an inner circle; as has already been made clear, we are not convinced of this, at any rate in Ontario and at least not in the fixed form which such a phrase implies. On the other hand, the issue *can* be rephrased. Given that the profession is a congeries of competing groups — in many respects (though it may be monolithic on some issues) — who then acts as broker, as "aggregator" of conflicting claims and interests? In the main, this would seem to be the role of the OMA (and of the CMA at the national level); and many of the things that happen in the medical-political world in this province *can* be interpreted in terms of the success or failure of the OMA in fulfilling this role. One tends to look to the OMA as the likely place for brokerage, since it is (apart from the College, which is precluded by its close relationship

⁶*Ibid.*

⁷*Ibid.*

to state authority from undertaking that kind of activity) the most comprehensive in its membership. But it is equally clear that on many issues important segments of the profession would not be prepared to accept the legitimacy of the OMA's acting in this way. The range of the OMA's activity is wide, but it is not all-embracing. Thus, it may well be more realistic to think of the brokerage function being performed, not by one organization, but by several; which one, will depend on the context. Even the College may act as broker when it comes to questions of intra-professional dispute over policy on entry to the profession or policy on professional discipline, both issues being specifically within its field of competence.

The establishment of the Canadian Association for the Advancement of the Health Sciences throws some light on both the internal and the external aspects of the politics of organized medicine. This organization may be said to have originated in the activities of a few people, mainly but not exclusively doctors, who were concerned about the lack of progress in expanding medical research in Canada. A sizable proportion of this group was Ontario-based. The group's attitude was that the Hall and Bladen Commissions had failed to come to grips with the pressing problems of medical research. Action began in 1965 when, as Mr. Gundy himself recalls, "a group of his scientific friends particularly among the Canadian Society for Clinical Investigations and the staff of the Toronto Hospital for Sick Children" told him "of their alarm at the shortage of funds for medical research in Canada and the seriousness of the threat this held for the future of medical standards". Accordingly, Mr. Gundy says, "Woods, Gordon and Company, management consultants, was commissioned to prepare a study of the problem". This report became known as the Gundy Report.

According to one of our interviews with an "influential" informant, the reason for the Commissions' failure to come to grips with the problem was the lack of any body to present the needs of medical research as such. The CMA "knew nothing about research", and "the OMA is no better informed". There was need, then, for a new organization to present the facts. The CAAHS was established as a follow-up to the Gundy Report, which was presented to the Prime Minister (with an accompanying letter from Mr. Gundy, from which the above quotations are taken) in January 1966. An informal action committee was set up in April to study what should be done subsequently, and the first organizational meeting for CAAHS was held at the University of British Columbia in June, in conjunction with the annual meeting of the Canadian Federation of Biological Societies. The second organizational meeting was held in Montreal in October 1966, in conjunction with the meetings of the Royal College and the Canadian Society for Clinical Investigation (the intention being to attract clinical researchers as well as pure scientists). It was at this meeting that the new Association was formally launched. At the time we talked to the Executive Director the Association's meagre funds were being supplemented by donations from Mr. Gundy and from interested organizations such as the Society for Clinical Investigation, the Canadian Arthritis and Rheumatism Society (whose Executive Director is promi-

ment in the medical research promotion movement),⁸ and the Canadian Heart Foundation (whose Executive Director is the Executive Director of CAAHS and which provides it with office space). Another informant suggested that the attempt by the CAAHS to set up local support groups has not yet met with much success, partly because of "the difficult position of the university doctor, who cannot just lobby for his own area of study without taking into consideration the priorities as they are set out by his university as a whole".⁹ There are, however, Chapters of the Association at Guelph, McMaster, Western Ontario and Toronto. The officers and committee chairmen are strongly Ontarian: of the twenty-one directors, twelve are from Ontario, including the two laymen on the board.

It may be argued that the case of medical research is somewhat unique. It is our impression, however, that this is not so; and that many other examples could be found of shifting coalitions and alliances of key groups in the policy-process in Ontario medicine.

⁸We were told that this gentleman, who is the Association's key contact in the Ontario legislature, "had made university needs better known in Ontario than in any other province".

⁹Another interesting, and significant, example of cross-pressures.

Part Three: The Regulation of the Doctor

Introduction

We have now outlined the basic structure of the medical profession in Ontario and have traced some of the connections between its various parts. Our next task is to look at the regulatory aspects. In Chapter 8 we consider the “gatekeeping” functions: regulation of entry to medical school, control of prelicensing internship, licensing procedures, and regulation of entry to hospital privileges. The regulation of entry to specialist practice is discussed in Chapter 9. In Chapter 10 we take up the question of discipline and the control of professional conduct. Finally, in Chapter 11, we discuss patient’s rights: mediation in disputes between doctor and patient, the problem of the “teaching patient”, defence against quacks and frauds, and (a matter touched upon briefly in Chapter 10 as well) quality control.

Chapter 8 Controlling Entry and the Right to Practise

... to make him partner in my livelihood
—Hippocrates’ Oath

In this chapter we consider the various stages through which a hypothetical doctor might pass from the point of entry to medical school to the granting of a licence to practise and beyond. Not all doctors in Ontario, of course, are “home-grown”: some come ready-made, or partly trained, from other provinces and other countries. But our hypothetical doctor provides us with a logical progression for orderly exposition. Thus, we deal first with entry to medical school and (briefly) with the student’s progress through it; then with internship; then with the licensing process in its various manifestations; and finally with entry to hospital practice. Postgraduate specialist training and residency are discussed separately in Chapter 9.

Reasons for Entry into Medical School

Before turning to entry to medical school it may be worth making a brief sociological digression into the (logically prior) question: what makes young men and women decide to take up medicine? There is much still to be learned about this, but such studies as there are suggest some lines of thought.

Investigations of the American medical student¹ indicate that family and social background play a large part in the initial decision. In one comparative study of medical students and law students it was found that medical students had more relatives who were doctors and law students more relatives who were lawyers.² The medical students differed from the law students in that they had generally made up their minds to enter the profession at an earlier age. This fact was related, it is true, to admission requirements; but it was also related to an earlier and more intensive interaction with doctors, and to the students' recognition of the status accorded to medicine in American society and its high rewards. The age at which the decision was made was found to correlate with the attitudes the students held about the profession: the 20 per cent who had made their decision quite early in life (and who, incidentally, were more influenced in making it by their fathers than by their peers) had fewer doubts about their choice and stressed the personal satisfactions to be derived from helping the sick. Those who had made their decision later (and who were influenced less by their parents than by their peers) were much less single-minded about medicine as a career — they had seriously considered other possibilities — and saw the intellectual challenge of medicine as its chief attraction.

A study by Anderson, Riches and McCreary of three groups — premedical students, ex-premedical students (or “defectors” from medicine) and natural science students³ — showed that the premeds (or “loyalists”) were more committed to medicine (“the only career that would really satisfy me”) and were much more likely to have reached a firm career decision before the age of fifteen. The “fact” about medicine that appealed to them most was the opportunity it afforded for working closely with people, whereas the “defectors” and the “scientists” were much more concerned about other things: the “scientists” with the high level of knowledge required in *their* chosen careers, the “defectors” with freedom of activity and a good income. The premeds were more self-confident, and even “cocky”, about how well they were doing in school, and were likely to go on doing.

When asked to rank thirteen occupations in order of prestige in Canadian society, *all three groups* put the physician first — above the college professor and the lawyer, and a long way above the businessman (whom they all agreed to place about half-way down the list). All ranked medical training at the top of a list of ten professional training programs in terms of difficulty.

¹The material briefly noted here is to be found in R. K. Merton *et al.*, *The Student Physician*, Harvard University Press, Cambridge, 1957.

²In the Evans and Anderson study of entrants to the four western Canadian medical schools in 1966, 10 per cent of the applicants (76 out of 764) reported a physician father. Dr. R. K. Evans and Dr. D. O. Anderson, “The Selection of Medical Students in Four Western Medical Schools”, *Canadian Medical Association Journal*, Vol. 96, February 25, 1967.

³Dr. D. O. Anderson, Eleanor Riches, and Dr. J. F. McCreary, “Medicine or Science — A Study of Career Decisions”, *Canadian Medical Association Journal*, Vol. 96, April 8, 1967, p. 1009.

The study also sought some reasons why the "defectors" had decided to abandon the idea of a medical career. Not very surprisingly perhaps, "another career appears more attractive" was ranked first in weighted rank order, with "poor marks" second, "length of the course" third, and "the practice of medicine interferes with personal life" fourth. Relatively unimportant were: "the unpleasant sights and duties a doctor must deal with" (eighth) and "disillusioned with the image of the doctor" (ninth). "The threatened implementation of medicare" was ranked least in order of importance (tenth).

Thus the "loyalist" tended to stay because he was highly motivated and attracted to the close relationship with people he expected to find in medical practice; the "defector" retained a high regard for medicine, but his values and needs seemed more akin to those of the "scientist" than to the premed group he had just left. As the authors point out, those who stayed fitted admirably the description of freshmen medical students reported by Howard Becker:

. . . freshmen enter medical school full of enthusiasm, pride, and idealism about the medical profession. For many it is the realization of a dream, a day they have looked forward to since childhood. They have worked hard to get in, are proud to have been accepted, and find it difficult to imagine themselves anything else but future practitioners.⁴

There follows, if other studies are right, a period of disenchantment (at least for many) as they proceed through medical school; but we discuss this evidence later.

Formal Requirements for Entry

A certain air of mystery surrounds the question of who gets into medical school and why. A letter from a third-year medical student at McGill, published in the *Canadian Medical Association Journal* in April 1967, voices some of the doubts of the applicants:

Having been accepted into a medical school and knowing a good many other people with roughly the same qualifications who also applied but who were rejected, one wonders why one's application was selected in preference to those of the others

Were the marks all that counted, or was the interview the most important thing? Were the MCAT results really considered? . . . Does having inside connections improve one's chances?

What about the applicant whose father is "a prominent local physician with a post at the university"?⁵

In reply,⁶ one of the authors of the study⁷ that had prompted this letter was able to dispose, if not of the specific issue, at least of the general principle behind the

⁴Howard Becker *et al.*, *Boys in White*, University of Chicago Press, Chicago, 1961, p. 79.

⁵"Letters to the Journal", *Canadian Medical Association Journal*, Vol. 96, April 8, 1967, p. 1070.

⁶*Ibid.*

⁷Dr. R. K. Evans and Dr. D. O. Anderson, *op. cit.* Dr. Anderson was the respondent to the medical student's letter.

last query. The study (of the selection of medical students in four western Canadian medical schools) showed that the acceptance rate for physicians' children was 39.5 per cent whereas the overall acceptance rate was 41 per cent. The reply went on to say:

Mr. Gray, in his letter, vividly describes the confused state of mind with which the prospective student views each obstacle put in his way. The sources of confusion are many: well-intentioned but misleading counselling, rumours, folk-lore, and the like Selection committees are often perplexed that students should perceive the selection process as unfair or biased. Their onerous task is but to select the best candidates⁸

What are the facts? The answer would appear to be that we do not know.

A recent study of applications to Canadian medical schools by Clarke and Fish⁹ provides much useful data but leaves open some important questions. In 1966-1967, 4,534 applications were filed for the 974 places available in Canadian medical schools. The number of *Canadian* applications (i.e., excluding those from the United States and overseas) was 2,866. But there were many multiple applications and the actual number of *applicants* was 1,815.¹⁰ The study shows a considerable disparity in the evaluation of applicants by the various schools. Of the 505 multiple applicants, 61 per cent received divergent evaluations, and 19 per cent were actually rated "clearly acceptable" by one school and "clearly unacceptable" by another. Clarke and Fish argue, however — as it were in justification — that:

Discussion with admissions officials regarding the standards they set for entry . . . indicates that these differences rest primarily with varying pre-medical course requirements, evaluations of the institution in which the pre-medical education was taken, and differing attitudes to personal characteristics such as age,¹¹ rather than with any basic differences in levels of academic accomplishment required.¹²

They nevertheless believe that multiple applicants may be the less qualified who make more than one application in the hope of increasing their chances.

Eight hundred and ninety places were offered to Canadian applicants in 1966. Seven hundred and forty-six (43 per cent) of the applicants were "clearly and unequivocally acceptable", representing 83 per cent of the number of places available. But if applicants were characterized in terms of the highest evaluation

⁸"Letters to the Journal", *op. cit.*

⁹G. Grant Clarke and David G. Fish, "Applicants to Canadian Medical Schools for 1966-67", *Canadian Medical Association Journal*, Vol. 96, April 1, 1967, p. 927.

¹⁰This was a small increase on the previous year (United States applicants dropped by about 10 per cent). Of the Canadian applicants, 12.9 per cent were women. (This was the mean: the Ontario percentage was 14.4.) The women applicants were slightly younger: 55.7 per cent were twenty-one or less, compared with 46.5 per cent of the men.

¹¹Author's note: Nothing is said, specifically, of sex, religion or ethnic origin.

¹²*Ibid.*

received, 157 "acceptable" multiple applicants would be added to the pool, bringing the total to 903 (the authors say 902) — which is very close to the total number of places available. Thus, say the authors, "even with a generous definition of acceptability (which includes nearly 100 persons rated by at least one school as unacceptable) there appears to be no excess of acceptable Canadian applicants over places available".

Further, 48 per cent of all the Canadian applicants were accepted and registered. The majority of these (75 per cent of 651 people) received no rating lower than "acceptable". But there were 126 people accepted who received marginal and/or "unacceptable" as well as "acceptable" ratings, and seventy-three were accepted whose *best* rating was marginal. These two groups demonstrate (say the authors) "that Canadian medical schools are still accepting a considerable number of applicants whose qualifications are in some doubt".

On the other side of the coin, thirty-six applicants received no ratings lower than "acceptable" *but were not accepted*. In fact, none of these had made more than one application, and it is possible, say the authors, that if they had done so they might have found a place in preference to others whose applications were more in doubt. Nearly all these "acceptable" rejects were reported from four medical schools, but which these were is not stated.

The authors conclude that few acceptable candidates failed to find a place, while the schools accepted some applicants whose qualifications were equivocal. "In essence," they claim, "this finding contradicts the popularly held view that Canadian medical schools are turning down well-qualified applicants." It may be said, with respect, that it *may* do so: whether it *actually* does turns on what the standards of acceptability in the various schools are and how they differ from school to school. These are big questions, the answers to which might well affect the validity of the authors' conclusions at several points. Returning to the passage quoted earlier: it may be true that the different interpretations of acceptability are little related to differences in the *academic* standards demanded, but that is hardly the point. It is not academic standards that are in question so much as how the schools go about interpreting "personal characteristics such as age . . ." and so forth. It is in this realm that most of the "rumours and folk-lore" persist, and it is precisely here that we most lack hard facts.

The *formal* requirements for entry to the Ontario medical schools are clear enough, however.

At Toronto, the student who has completed his high school studies with the required standing in the prescribed subjects may move along one of three main routes: he may seek to enrol in the two-year premedical course; he may first complete a three-year (general) degree course in arts or science in an approved university; or he may take the four-year honours course in Biological and Medical Sciences at Toronto and, if successful, then apply to enter the *second* year of the

four-year professional course for the M.D. (Students moving along the other two routes enter the first year of the professional course.) All applicants for first year premed must take the aptitude test of the College Entrance Examination Board at Princeton. The Toronto regulations state that:

Although the great majority of students who successfully complete the premedical course will go on to take the professional course, the Committee on Admissions of the Faculty of Medicine will have the authority to review the records and standing of all students in the second premedical year before their admission is finally recommended to the professional course. Students who have repeated a year or had supplementals may find themselves in competition for a place in the course with students who have obtained a degree in Arts or Science.

The premed entry is highly competitive, and we were told that Toronto "gets its best students that way".

The quota of acceptances into first year premed in the session 1966-1967 was 135. The Calendar warns:

Only in exceptional circumstances are students from outside the province admitted to the first premedical year. Students from other provinces (and abroad) should complete their degree and seek admission to the first professional year . . . (and) only in exceptional circumstances will candidates over thirty be admitted.

All applicants for the professional course are now required to take the Medical College Admission Test administered by the Psychological Corporation of New York. It is said that race and religion are not factors affecting admission decisions, but:

. . . in the past, the School discriminated against female applicants to premedicine. This is no longer the case, although upon enquiry, a Grade Thirteen female student would be advised to take a degree course in Arts or Science in preference. There is no sex discrimination for entrance into the professional years.

This is disarmingly frank. We have already discussed (in Chapter 3) the "rumours and folk-lore" relating to women applicants — though those we quoted came from highly reliable and respected established women doctors who may be presumed to know what they are talking about.¹³

¹³The following is from the notes of one of our research assistants: "Dr. — says, yes, there is discrimination at the intake level: women have to be better than men, an average of 80 per cent to be accepted. It is still hard to get an internship when you want it (see next section of this chapter). Of the thirty-two internes at — (Dr. —'s hospital) only two are women. When the men tell her that the women are bright she is not surprised. It is the only way they get the internship there. They tend to have been top or second in the graduating class. Postgraduate work is the same. It is hard for a woman to get taken on by a specialist as his resident. All along there is the fear that women will drop out and that money will have been wasted . . . She had been talking to Dr. —, the Assistant Dean at —, who told her sometimes the quota is not taken up. Why? Dr. — says — is prejudiced against women on the grounds that they will not complete the course or will drop out soon after. He was just the same when he was at —."

(Note: Dr. —'s remarks should not be taken as referring only to Toronto; other schools also were under discussion.)

In general, says the University of Toronto (in a submission to the Committee on the Healing Arts):

. . . in considering applicants to premedicine or medicine the greatest weight is given to previous academic performance. References (or high school Principal's ratings) are taken into consideration, though they are not usually decisive. Entrance examination scores are considered as less important than the record of the previous academic performance. The ability of an applicant to support himself through four years of the professional course is an important consideration for admission. Although applicants must be landed immigrants, they need not be residents of Ontario prior to entering the First Professional Year. This means that at least for the first year in this course such applicants need to be able to support themselves, since they are ineligible for an Ontario Government Award.

It needs to be understood that many factors which are taken into consideration when evaluating an applicant for admission to Medicine are not explicitly determined. The evaluation of an applicant depends to some degree upon the opinion of the members of the *pro tem* Committee on Admissions.

The professional program at Queen's also is a four-year program. About fifty students are admitted annually to the first premed year, and about twenty-five students who have taken university work other than the Queen's premed course are taken into the first professional year, with a minimum of two years university work required and preference being given to graduates. The MCAT is now mandatory for applicants seeking admission to the first medical year. "About 10 per cent" of the applicants are interviewed.

"Approximately 300 applications" for admission to the first medical year are received annually (actually, over 400 in 1967) and of the seventy places available, approximately forty are filled by ex-premed students: i.e., those who have completed two years (after senior matriculation) of the four-year honours B.Sc. program in the Life Sciences at Queen's. The remaining places are filled by students who have earned a B.A. or a B.Sc. degree at Queen's or another approved university. The majority admitted are Canadian *citizens* and residents of Ontario (see figures in Chapter 6). Applications are accepted also from: residents of other Canadian provinces; children of Canadian citizens resident abroad; children of Queen's medical graduates resident abroad; residents of Jefferson, Lewis and St. Lawrence counties in northern New York State; and foreign students sponsored by the External Aid Office.

Race, religion and sex play no part (say Queen's) in the selection of students for the first medical year. However:

. . . of the fifty students admitted to the (premed) program who are *allowed to register their intention* to proceed into the four-year medical program, a maximum (sic) of ten places (20 per cent of fifty) are allotted to women students. Experience has shown that, *although the academic failure rate is lower among women than among men* (i.e., a higher standard is demanded on admission?) the attrition due to changes in career plans is approximately twice as high. Women often leave medical studies on getting married; men seldom do. (Emphasis and words in parentheses added.)

The number of graduates of the medical program (says the Queen's submission) is not limited by a shortage of faculty nor by inadequate physical facilities (the usual reasons advanced, certainly by Toronto), but by the number of patients available for teaching in the Kingston hospitals.

At the present time, the Kingston area provides enough hospital patients to allow a graduating class no larger than about sixty-five students. As Kingston and the surrounding areas increase in population, it is anticipated that the number of students admitted to the medical course can be gradually increased.

At the University of Western Ontario no students are considered from outside Canada for the medical program "unless there are special circumstances":

Occasionally, a child of an alumnus may be considered. One or two places are available in the first year of the medical course for students from developing countries who are sponsored by the External Aid Office. Students who have taken their pre-medical training at U.W.O. are given first consideration. Consideration is then given to students who have graduated from neighbouring universities such as the University of Windsor, McMaster University, or the University of Waterloo.

Undergraduate Experience

What happens to the medical student along the way? The University of Toronto has produced some very comprehensive statistics on drop-outs for the period 1947 to 1966. (The rates quoted are the *mean* percentages for the whole period.) The drop-out rate is highest in the first two medical years: 9.12 per cent and 5.82 per cent. It falls to 1.45 per cent in the third year and is negligible (0.34 per cent) in the final year.

The degree students have a higher drop-out rate than the premeds in the first year (11.44 per cent to 8.37 per cent) but this is due largely to non-academic factors. There is very little difference between the two groups in drop-outs due to academic failure (5.66 per cent premed, 5.44 per cent degree students). The drop-out rate for non-academic reasons, on the other hand, is 2.71 per cent for premeds, 6 per cent for degree students.

The degree students have a *much* higher drop-out rate in the second medical year (10.67 per cent compared with 4.16 per cent), and here it is likely to be due to academic rather than non-academic factors (academic: 8.05 per cent for degree students, 3.33 per cent for premeds; non-academic: 2.62 per cent for degree students, 0.83 per cent for premeds). In the third year, the degree students have a slightly higher academic drop-out rate (1.66 per cent compared with 0.79 per cent), but by the final year there is virtually no difference between the two groups.

The attrition rate is one aspect of the problem of what happens to the medical student on his way through school. His attitudes and ideals are another. Howard

Becker's characterization (noted earlier) of the freshman as an idealist is in sharp contrast to the popular stereotype of the medical student as tough and unfeeling. (There is considerable literature on this, but again it is mainly American.) The purpose of Becker's study, which was carried out at the University of Kansas Medical School,¹⁴ was to discover what happened to the student's idealism as he was brought, progressively, face to face with the realities of professional practice.

The medical students enter school with . . . the idealistic notion . . . that the practice of medicine is a wonderful thing They believe that medicine is made up of a great body of well-established facts that . . . will be of immediate practical use to them as physicians In several ways the first year of medical school does not live up to their expectations. They are disillusioned when they find that they will not be near patients at all, that the first year will be just like another year of college . . . (that) the faculty . . . know nothing about the practice of medicine . . . and . . . (that much of) the subject matter itself is irrelevant, or as the students say "ancient history".

The student is told that there is far more to medicine than he can ever learn, and the harder he works the more he discovers the truth of this statement. He begins to learn that he must select "what the faculty wants", absorb "tips" and discover "short cuts". Overtly, there is cynicism, griping and minor cheating; but:

. . . the students keep their cynicism separate from their idealistic feelings and by postponement protect their belief that medicine is a wonderful thing, that their school is a fine one, and that they will become good doctors.

The sophomore year does not differ greatly from the freshman year:

Both the work load and anxiety over examinations probably increase. Though they begin some medical activities . . . most of what they do continues to repeat the pattern of (college). Their attention still centres on the problem of getting through school by doing well in examinations.

The student has been led to expect that once he reaches the clinical years he will be able to realize his idealistic ambitions to help people. Not so.

. . . they find themselves working to understand cases as medical problems rather than working to help the sick, and memorizing the relevant available facts so that these can be produced immediately for a questioning staff man The student becomes preoccupied with the technical aspects of the cases with which he deals because the faculty requires him to do so.

He also finds himself "low man in the hierarchy", having to content himself with "mere vicarious participation in the drama of danger, life and death".

Nevertheless, his original idealism "reasserts itself as the end of school approaches"; but it is an idealism informed now by a new and peculiarly professional

¹⁴See, for example, H. S. Becker and Blanche Geer, "The Fate of Idealism in Medical School", *American Sociological Review*, Vol. 23, February 1958, p. 50.

bias, an idealism of method and behaviour. Becker and Geer conclude that some of the student's determined idealism at the outset is reaction against the lay notion, of which he is "uncomfortably aware", that doctors are money-hungry cynics. He counters this "with an idealism of similar lay origin stressing the doctor's devotion to service". This idealism soon meets a set-back as the student finds it will not be relevant, at least for a while:

... medical school has, it seems, little relation to the practice of medicine as they see it. As it has not been refuted, but only shown to be temporarily beside the point, the students "agree" to set this idealism aside in favour of a realistic approach to the problem of getting through school. This approach, which we have labelled as the cynicism specific to the school experience, serves as protection for the earlier grandiose feelings about medicine by postponing their exposure to reality to the distant future. As that future approaches near the end of the four years and its possible mistreatment of their ideals moves closer, the students again worry about maintaining their integrity, this time in actual medical practice.

He starts to worry about ethical and career problems. For example:

Many seniors consider specialty training so that they will be able to work in a limited field in which it will be more clearly possible to know all there is to know (sic), thus avoiding the necessity of dealing in a more ignorant way with the wider range of problems general practice would present. In the same manner they think of schemes to establish partnerships or other arrangements making it easier to avoid a work load which would prevent them from giving each patient the thorough examination and care they now see as ideal.

In a word, the next stage in the student's career socialization is about to begin.

Internship

At the end of his fourth academic year in the professional course the Ontario student takes his university finals and the Medical Council of Canada examinations.¹⁵ After he passes these, he will not be able to practise in Ontario for at least another calendar year, which must be spent as a junior interne. The year has traditionally been a rotating or "mixed" internship; but, increasingly, the fourth professional year is becoming a clinical clerkship — a kind of pre-interne internship (at least in part), so that a straight internship after graduation may often be more appropriate, particularly for those intending to specialize. (Some students are employed during the summer preceding their final year as "student internes".)¹⁶

The junior interne year must be completed to the satisfaction of the College of Physicians and Surgeons before it will grant the certificate of internship which the Medical Council of Canada requires before it will award the L.M.C.C. —

¹⁵That is to say, if he has been successful in his earlier years.

¹⁶The Ontario College is currently studying methods by which the medical student serving as a clinical clerk or student interne in a teaching hospital can be provided with legal recognition (though not necessarily registration) under the Medical Act.

without which the graduate cannot practise. This gives the College — at least in principle — complete control of the type and location of the interne year. A doctor whose internship has been other than a rotating or “mixed” internship (including experience in general medicine, general surgery, obstetrics, gynaecology and paediatrics) must satisfy the College that he has received an acceptable training in these subjects as an undergraduate clinical clerk. At present the College accepts a letter from the student’s dean of medicine as evidence of this.

The Canadian Association of Medical Students and Internes alleges that the College uses its influence to try to prevent graduates from interning in the United States, presumably on the ground that, once lost to an American hospital, the graduate may not return to Ontario. CAMSI is strongly critical of this policy (if, indeed, it is a policy) arguing that it is an unwarrantable restriction of the freedom of choice of the newly qualified doctor. It argues that the College is far more restrictive in this respect than other provincial licensing bodies, though “it does recognize a few American hospitals in very large centres”. The junior interne year must be spent either in a Canadian hospital approved for interne training by the CMA, or (as the College puts it) “in an American hospital that has full affiliation with an approved medical school”. (The College prepares and distributes to faculty offices a list of acceptable American hospitals in January each year.)

Though accreditation of hospitals for junior interne training is a function of the CMA, the College has established its own scheme of inspection for Ontario hospitals.¹⁷ The CMA has been concerned to establish a uniform standard, chiefly of physical facilities and staffing, for interne training across Canada. The College is more interested in the content of the interne program in a given hospital. Hospitals are inspected by a two-man team, which often includes a youngish doctor who is only a few years away from his own interne and residency training. The teams are drawn from a panel, known as the Board of Inspection of Interne Training Programs, selected by the Registrar on the basis of recommendations by knowledgeable people. Between October 1966 and February 1967, the interne training programs of eight hospitals were reviewed. Six were approved, one was not approved and one was provisionally approved (for one year). Nine doctors made up the panel for these visits: three from Toronto, and one each from London, Hamilton, Kingston, Scarborough, Windsor and Barrie.

Since 1965 no one may be legally employed as an interne in Ontario unless he is registered as such under the Medical Act — that is to say, unless his name is on the Educational Register of the College. An unregistered interne is liable to prosecution under Section 51 of the Medical Act, and presumably the staff of the hospital that employed him might be disciplined by the College. This move was prompted by the increasing number of unregistered people (many of them

¹⁷In 1966, 1,304 internes and residents were reported in Ontario. All but seventeen were interning in hospitals approved for interne and resident training.

of foreign origin¹⁸) who were being employed in the hospitals, sometimes for lengthy periods and with very little hope of ever getting a licence to practise.¹⁹ Hospitals have been warned that they are not permitted to evade this obligation by calling such people "clinical clerks" and that "foreign students from non-approved schools should not be permitted to carry out medical procedures, even under supervision". (An interne is defined as a physician working as a member of the resident medical staff of a hospital under the supervision of the active medical staff of the hospital.)

The College regards written acceptance of an internship as a binding agreement to be fulfilled in a manner satisfactory not only to the hospital but also to the College. Breaches of agreement are potential disciplinary matters and could lead to removal from the Educational Register. Internes have drug prescribing privileges, but they may not charge fees for their services, and they may not practise or prescribe outside the hospital where they are employed. The interne may become a member of the Canadian Medical Protective Association. The College will issue the Certificate of Internship required by the Medical Council of Canada on receiving a report from the hospital that the interne has satisfactorily completed eleven months of the required year of internship. The report from the hospital must state that the interne's performance has been "satisfactory in respect to knowledge, skill and deportment".

Licensing

Licences to practise medicine are granted by the provincial authorities on their own terms and conditions and there are, at the time of writing, significant variations from province to province. An appendix to this chapter summarizes some of the major requirements in each province and (for comparative purposes) briefly states the procedures in Britain and the United States.²⁰

Since the College of Physicians and Surgeons of Ontario opened its doors just over 100 years ago rather more than 20,000 doctors have had their names

¹⁸Of the 387 graduates of foreign medical schools interning in Ontario hospitals in 1966, all but twenty-two were registered with the College. A satisfactory procedure for the registration of internes has been developed with almost all hospitals, but in a few instances difficulties occur if the chief of a department makes an appointment without advising either the hospital administrator or the College. A typical pre-1965 example that came to our attention was the case of an Indian doctor who was appointed a rotating interne at Kingston General Hospital in 1960. The College subsequently advised the hospital that the man's Indian medical school record was so inferior that he would never be accepted for full licence in Ontario.

¹⁹We were told at one well-known Toronto hospital that one member of the Junior Staff had been on the Educational Register for thirteen years — nearly as long as the Educational Register has been in existence.

²⁰In comparing provincial licensing practice it must be borne in mind that we are dealing with very different scales of magnitude from province to province. In 1960, for example, the number of Ontario doctors was 7,908, compared with 895 in Saskatchewan and 87 in Prince Edward Island.

inscribed on the Register. About half of these hold current licences. The basic requirements for obtaining a full licence to practise are as follows:

- 1) The applicant for a licence must show that he possesses a degree or other medical qualification granted by a university, medical college or examining body whose standards of undergraduate education and examination are of a quality acceptable to the College of Physicians and Surgeons, and that he has completed at least one year of internship in an approved hospital.
- 2) He must be a Canadian citizen or possess landed immigrant status.
- 3) He must be a Licentiate of the Medical Council of Canada (L.M.C.C.).²¹
- 4) He must (where appropriate) show evidence of good standing with the licensing body in whose jurisdiction he last held a licence (inquiries are made by the College).
- 5) He must produce testimony of good character and that he is "a fit and proper person to hold a licence"; and, in particular he must disclose whether he has ever suffered from or been treated for mental illness, alcoholism or drug addiction, whether he has ever been convicted of an indictable offence, and whether he has ever been disciplined by a professional licensing body for misconduct.²²

These are fairly standard requirements: the major exception is the requirement that he must have passed the examinations of the Medical Council of Canada. Not all provinces *require* their licensees to possess the L.M.C.C., though it would appear that most newly qualifying Canadian doctors now take it as a matter of course. It is important to note that the L.M.C.C. is *not* a licence to practise medicine: it merely allows the holder to register with a provincial licensing authority (provided it will accept him on other grounds) without taking a provincial licensing examination. As we have seen, the provincial examination was abolished in Ontario in 1934, but examinations are still held in some provinces (Nova Scotia, for example).

The crux of the licensing problem in Ontario²³ (and the one around which most of the controversy currently centres) is the requirement regarding "accept-

²¹The subjects of examination for the L.M.C.C. are (a) medicine including therapeutics, (b) surgery, (c) obstetrics and gynaecology, (d) public health and preventive medicine, and (e) paediatrics. There are written examinations in each subject; a clinical and oral examination in medicine, surgery and paediatrics; and an oral examination in obstetrics and gynaecology, and in public health and preventive medicine. Where the examinations are taken conjointly with final examinations for a degree in medicine, the examination is first marked by the Medical School and the papers of the *successful* candidates are then forwarded to the Medical Council of Canada.

²²We were told that an applicant who cannot make such a declaration is not automatically disbarred from a licence—but his case is looked at very carefully, and he may be placed on the Special Register for a period of probation.

²³Though not quite the whole of it (see below).

able" medical schools and "acceptable" medical qualifications. The basic policy of the College (strictly, the Council of the College acting on the advice of its Education and Regulation Committee) has been to distinguish between applicants on the basis of the medical school from which they obtained their *original* medical degree *irrespective of later qualifications*, and with few exceptions to categorize medical schools *en bloc* according to the country in which they are situated. For example, the College accepts all Canadian and U.S. colleges (except the California College of Medicine — a former osteopathic college) and all British schools, but *no* Indian medical schools. Some schools are fully accepted, some are given a qualified acceptance, and some are unacceptable. This is not to say that a graduate even of an "unacceptable" medical school will *never* get a licence in Ontario (though in some instances, as things stand at present, that may be the case²⁴). What it does mean is that he must do further approved medical training in Canada or elsewhere before being accepted. These general principles will become clearer as we proceed, and it will be best to proceed by categories.

The Ontario Medical Student

As will already be apparent from earlier discussion in this chapter, the licensing process for the Ontario medical student begins before he takes his finals. Indeed, at one time, it could be said to begin from the day he entered medical school, for until 1966 all medical students at Ontario universities had to register with the College at the start of their professional course and pay a fee of two dollars. This requirement, however, was waived for those enrolling for the first time after September 1966. To summarize the facts stated earlier in this chapter, the Ontario medical student must:

- 1) Apply to the College (in the latter part of his final year) for an Enabling Certificate²⁵ to permit him to sit the examinations of the MCC (this certificate is issued on the basis of matriculation in the proper subjects, satisfactory performance in medical school, and good character).
- 2) Pass the MCC examinations (which he can take conjointly — in all Ontario universities — with his finals).
- 3) Pass his finals.
- 4) Complete a year of approved internship after graduation.

²⁴Such a graduate must (among other requirements) take *at least the last two years* of a medical course in Canada or in some other "approved medical school" country, and must be awarded the degree. In order to do this, of course, he must find a medical school that will accept him and this is not an easy task for a foreigner (see second section of the chapter for Ontario universities). A modification of this rule for specialists has recently been introduced (see below).

²⁵Strictly speaking, the Interim Certificate. The Enabling Certificate proper is issued to him, without further fee, on graduation.

- 5) Obtain from the College at the end of this year a Certificate of Internship and produce it to the MCC. (In return for this he receives his Licentiate of the Medical Council of Canada.)

He is now in a position to apply successfully for full registration with the College of Physicians and Surgeons and a licence to practise. This is issued to him on payment of a registration fee (in 1968 fifty dollars) and his first biennial licence fee (in 1968 thirty dollars) which he must continue to pay for the rest of his professional life in order to keep his licence. As soon as his name is inscribed on the Register he is entitled to hang up his shingle.

The Medical Student from Another Province

A medical student in another province who decides to practise in Ontario after graduation is treated in exactly the same way as an Ontario graduate; and, provided his university holds its final medical examinations conjointly with those of the MCC, he can apply to the Ontario College for an Interim Enabling Certificate before he sits for his finals.²⁶

The Established Doctor from Another Province

An established doctor from another province who wished to move to Ontario would have to comply with the basic requirements for a licence in Ontario set out at the beginning of this section; and if he did not possess the L.M.C.C., he would have to obtain it (this could conceivably happen, say, to a British immigrant doctor who had practised in one of the provinces that have reciprocity with the U.K. General Medical Council).²⁷

The Immigrant Doctor

Before examining in detail the controversial question of the immigrant doctor, we shall set out the existing arrangements. It should be borne in mind, however, that these are currently under discussion through the medium of the newly created Federation of Provincial Medical Licensing Authorities of Canada (q.v.). Table 2 shows the number of licensed immigrant doctors coming into Ontario in the period 1951 to 1966 by area of origin. Evidently the foreign doctor has been, and still is, a major factor in the total doctor manpower situation in the province. The American medical schools are a negligible source of supply.²⁸ Taking the period as a whole, approximately equal numbers have come from what (for the sake of brevity but without, it is hoped, occasioning any offence) may be called the "White Commonwealth" and from other countries of the world (chiefly

²⁶Apparently it is not uncommon for Canadian doctors to register and maintain their licences to practise in more than one province.

²⁷Many doctors (in the Maritimes, for example) stay only a short while in their province of first registration and then move on to another province.

²⁸Moreover, some "immigrants" from U.S. universities may be Canadians returning home.

Europe and Asia). Until the mid-1950's immigrant doctors from the latter countries outstripped those from the "White Commonwealth", but since 1963 there has been a marked decline in their numbers. There was a large influx of doctors from Britain in the late 1950's. In all, immigrant doctors account for nearly 30 per cent of all those licensed in Ontario over the period 1951-1966. It will be seen from the table that there were 440 new registrations in 1966. Of these, 219 G.P.'s and eight specialists received their undergraduate medical training in Ontario medical schools, eighty G.P.'s and thirteen specialists in other provinces, eighty-one G.P.'s and thirteen specialists in "White Commonwealth" countries and the U.S., and sixteen G.P.'s and ten specialists in other countries.

TABLE 2
Immigrant Doctors, 1951-1966

Date	Graduates from Canadian Universities	Graduates from U.K., Australia, N.Z. & S.A.	Graduates from Universities in U.S.A.	Graduates from Other Medical Schools	Total Immigrant Doctors (Ontario)	Total Immigrant Doctors Canada as a Whole ¹
1951	305	20	1	43	64	N/A
1952	297	29	3	52	84	N/A
1953	335	51	2	70	123	402
1954	304	67	7	86	160	311
1955	344	55	4	99	158	333
1956	343	88	2	88	178	415
1957	307	125	3	70	198	635
1958	221	118	3	82	203	394
1959	224	91	3	98	192	439
1960	266	59	5	71	135	441
1961	291	48	10	55	113	N/A
1962	293	48	6	47	101	N/A
1963	300	55	2	28	85	N/A
1964	335	52	0	25	77	N/A
1965	307	49	2	27	78	N/A
1966	320	91	3	26	120	N/A
Total	4,792	1,046	56	967	2,069	

SOURCES: Annual Report of the College of Physicians and Surgeons of Ontario, January 1967, and *Canadian Medical Association Journal*, Vol. 85, November 18, 1961, p. 1162.

¹This figure is the number of doctors admitted to Canada as immigrants. The Ontario figure is the number of doctor immigrants to Ontario *actually granted licences*. In the period 1950-1960 in Canada as a whole, 4,866 new registrants were graduated from foreign schools. Ontario's share of this total was 1,550 — i.e., roughly a third. The total new registrants who were graduated from Canadian schools was 9,805, of which Ontario's share was 3,243 — again, about a third. Appendix IV, p. 148 sets out the totals for Canada as a whole and compares them with the situation in the U.S. in the same period.

²Compare this with twenty-three *applications* in the decade 1930-1939, and six actual *registrations* in the same period, from these countries.

Taking a longer period (1930-1966): 2,201 foreign medical graduates were registered in this period in Ontario out of a total number of registrations of 11,225. Of these, 1,055 came from United Kingdom medical schools. Other significant "exporting" countries were:

Austria	88
Germany	182
Hungary	145 (the majority after the 1956 uprising)
The Netherlands	69
Poland	95
South Africa	37 (all after 1953)
China	29
Czechoslovakia	37
France	42
India	22
Latvia	21
Switzerland	24
Turkey	15
Yugoslavia	28
Australia	18
Estonia	10
Greece	12
Lebanon	11
Lithuania	10

The following countries exported less than ten in this period: Belgium, Bulgaria, Cuba, Denmark, Egypt, Finland, Haiti, Hong Kong, Iraq, Israel, Korea, Malta, Mexico, New Zealand, Pakistan (2), Philippines, Portugal, U.S.S.R., Rumania, Sweden and the West Indies (7).

A comparison of the two totals (for the period 1930-1966 and for the period 1951-1966) demonstrates that the vast majority of immigrant doctors have come to Ontario since the end of the Second World War.

Graduates of Medical Schools in the United Kingdom, Eire, Australia and New Zealand, the Republic of South Africa and the United States

Graduates of American medical schools can, for all practical purposes, be discounted in what follows: they form a negligible proportion of the flow of im-

migrant doctors to Canada, and there is very little chance of attracting them in large numbers; in fact, the flow tends to be the other way.²⁹

On paper, graduates of medical schools in the above countries³⁰ (Jamaica has recently been added) are accorded exactly the same status as the Canadian graduate. However, the requirement that they must possess the L.M.C.C. means that they are placed on the Special Register until they have passed the examination. During this time they may legally practise only in a hospital or as an assistant to, and under the supervision of, a fully licensed practitioner. We have been told that this is very laxly complied with — at least so far as it relates to the duties the immigrant doctor actually performs; but it does mean that he cannot work fully independently (he can accept professional fees, prescribe drugs, and sign certificates). To argue that he is no worse off than his Canadian counterpart is to evade three facts: that the Canadian "immigrant" to Ontario (from another province) usually has the L.M.C.C. already; that "assistantships" are often hard to obtain, partly because not all practitioners like accepting the responsibility for the immigrant doctor; and that the "White Commonwealth" applicant is frequently a mature doctor who may very well be deterred by the slightly humiliating prospect held out to him upon arrival. It cannot be known how many such doctors *might* have come to Ontario but have gone to other provinces with less exacting requirements, but we know there are some.

Although there is no longer reciprocity with the U.K. General Medical Council (this ceased in 1927), all British and Irish medical schools are acceptable to the College, with one exception. The College is somewhat sceptical of the English, Irish and Scottish Conjoint Boards (which award the M.R.C.S., L.R.C.P.³¹

²⁹A rough indication of the loss to the United States (usually estimated at from 8 to 10 per cent) may perhaps be gleaned from licensing figures published annually by the AMA. In 1965, for example, 143 graduates of Canadian medical schools (they need not, of course, have all been Canadian) were examined for licensing by American State Boards, and 135 passed. Most of them were licensed in California, Michigan and Minnesota (partly, perhaps, because in these States — though there are other requirements — there is none regarding citizenship). Roughly sixty were graduates of one university — McGill — and the great majority were drawn from four schools: McGill, Dalhousie, Manitoba and University of Toronto. The "loss" of graduates of Ontario schools appears to have been about thirty, but it does not follow that all were practising in Ontario when they made their decision to apply for an American licence, nor even (indeed) that all would necessarily leave Canada on obtaining it.

³⁰It should again be noted that the distinction is based on the country in which the medical school is located, not the country of origin. Thus it is not true that the college "discriminates against Indians", for example. If the Indian is a graduate of one of these medical schools, he will be accepted. Discrimination is based on medical schools, not race. We have found no evidence of racial discrimination in the licensing process as such. A Canadian who obtained his medical education in a country whose medical schools were not approved would be treated in exactly the same way as a national of the country concerned.

³¹Member of the Royal College of Surgeons and Licentiate of the Royal College of Physicians, respectively.

or equivalent) and of the Licentiate of the Society of Apothecaries,³² and it will not accept the L.A.H. Dublin awarded by Apothecaries Hall, Dublin, without further educational requirements.

The "Conjoints" are not medical degrees but qualifications offered by professional bodies (the Royal Colleges); and it is generally accepted, even (though reluctantly) by the bodies themselves, that their standards *are* somewhat lower than those set for a degree from a British university (typically the M.B., B.S.). In the case of the doctor who has taken one of these examinations in place of his university examinations, the College requires that he submit a statement from his medical school showing whether he had tried and failed the university examinations or proceeded directly to those of the Conjoint Board. *In the former case*, depending on the quality of his postgraduate training, the College may require him to take additional hospital training in Canada before granting him full registration. (We saw in the files of the College one case of an M.R.C.S.-L.R.C.P. who failed his M.B. examinations twice. He was required to take a one-year rotating internship and pass the basic science examinations of the College — see below.) This is a very curious and indeed illogical provision. In fact, almost all newly qualified doctors in Britain today are graduates (in a recent year only about 2 per cent of the new entrants to the profession had *only* the Conjoint qualification), though many take the Conjoint as a kind of "trial run" before their university finals and thus have both qualifications when they graduate. It is interesting to note that, of the 110 U.K. candidates taking the MCC examinations in 1965, only eleven possessed the Conjoint qualifications alone. The majority of Conjoint candidates nowadays are from overseas (i.e., come from outside Britain: from Africa, India and other countries).³³

In summary, then, a doctor who was trained in one of these countries must meet the following requirements to obtain full registration:

- 1) Pass the MCC examinations.
- 2) Produce evidence of satisfactory degree standing or (in the case of a British physician) an acceptable alternative qualification.
- 3) Submit a birth certificate and a passport photograph for purposes of identification (the latter is to assist in preventing impersonation, but unfortunately, it is liable to misinterpretation; the College might consider withdrawing it).

³²It is one of the ironies of history that this ancient qualification, the first to be granted to general medical practitioners in England (see Chapter 2) has long been reduced to the status of an "also-ran". It is known rather unkindly in England as "the Blackfriars M.D.", a reference to the district of central London in which Apothecaries Hall is located.

³³Interview by the author with the Registrar of the Royal College of Surgeons of England, June 1967. The main qualifications offered by the two English Royal Colleges today are the *postgraduate* M.R.C.P. (the "Membership" of the Royal College of Physicians) and F.R.C.S. (the "Fellowship" of the Royal College of Surgeons).

- 4) Submit an up-to-date certificate of good standing from the licensing body in whose jurisdiction he last held a licence, and evidence that he is "a fit and proper person" to practise in Ontario.
- 5) Submit evidence of Canadian citizenship or landed immigrant status.
- 6) Pay his fees (as for Canadian graduate — see above).

Graduates of Medical Schools under Qualified Approval

The medical education offered by schools in this category is, in the opinion of the College, of lesser quality than that obtainable in Canada, "but such that deficiencies can be made good in many instances (sic) by a period of hospital training in Ontario" or "in university-affiliated hospitals elsewhere in Canada". The argument is two-fold: that the College has enough information about these schools to be more or less certain that deficiencies can be made good, at least in principle; and that the period of internship anyway provides a probationary period during which the candidate's standards may be authoritatively assessed. The College claims that the evaluation of schools in this category is a continuing process as new information comes to hand, and that it revises its assessments each year. At present, this second category includes the medical schools of most European countries, two in the Middle East (Hadassah-Hebrew University in Israel and the American University at Beirut), the University of Hong Kong, the Japanese Universities, and a number of schools in South America. All other schools are consigned to the third category, which we shall discuss in a moment.

Graduates of medical schools in the second category are required, first, to obtain the certificate of the Educational Council for Foreign Medical Graduates. This provision was introduced in Ontario in 1960, its purpose being to "ensure" that the candidate is "a safe person to carry out the duties of an interne in an Ontario hospital".

The ECFMG is an American organization. The Board of Trustees is composed of representatives of the Federation of State Boards of Medical Examiners of the United States, the American Medical Association, the Association of American Medical Colleges, the American Hospital Association, and the New York Academy of Medicine. The examination, which was instituted in 1958, is held twice a year at centres in the United States and Canada and at over 100 centres abroad. There are two parts: one, the medical portion, is a written examination of the multiple-choice type covering the major medical subjects and the basic sciences; the other is a test designed to assess the candidate's comprehension of spoken English. It is a screening mechanism only, and the College claims that it has proved successful as an indicator of the suitability of candidates for junior interne work in Ontario.³⁴ There have been criticisms of the examina-

³⁴The American Hospital Association denies accreditation to any hospital having on its staff "in a patient care situation" any graduate of a foreign medical school who does not have a full licence to practise or who has not been certified by the ECFMG.

tion, however, on the ground that it is much too simple (it was taken with 90 per cent success by a group of American nurses, for example) and is therefore no proper test of medical knowledge. Candidates are accepted from any school that is on the World Health Organization's list (the World Directory of Medical Schools).

Candidates in Ontario who have already passed the examination of the MCC, or have obtained certification in a specialty by the Royal College of Physicians and Surgeons of Canada, or have satisfactorily completed a Canadian or American one-year rotating internship, are not required to take it.

On passing the ECFMG and provided he is accepted by an approved hospital as an interne, the candidate is placed on the Educational Register. He must normally serve two years as an interne, one of which must be a rotating internship. At some point (notionally during the course of his internship) he must pass examinations (arranged by the College with a medical school) in up to six basic sciences and English, and must obtain the Licentiate of the Medical Council of Canada. There is one further provision: the candidate must have begun his further training (in Canada, Britain or the United States) within ten years of obtaining his medical degree. (He must also, of course, possess landed immigrant status and otherwise comply with the general regulations of the College that apply to *all* applicants.) The six subjects in the basic science examinations are anatomy, biochemistry, bacteriology, pathology, pharmacology and physiology. The candidate is allowed three years to pass them (with rewrite provisions), and "only by special permission of the Executive Committee" (of the College) may he be registered for a fourth year on the Educational Register.³⁵

Graduates of "Non-approved" Medical Schools

These, who include (for example) all Indian doctors, were until quite recently under very severe restrictions indeed. Their degrees were not, and indeed still are not, accepted as in any way equivalent to those of a Canadian medical school. The College argument is that the education obtainable in these schools is "so deficient that only occasional and exceptionally able graduates can attain parity with Ontario standards". This implies that they must be, to a considerable extent, "re-educated". It has been well established, says the College, "that graduates of schools in this category cannot be brought up to an acceptable level of knowledge and competence by the usual hospital training alone".³⁶

³⁵It would seem that the College began to question the quality of certain overseas medical schools as early as 1943; for it was in 1944 that the College made its first regulation requiring foreign applicants to take additional training, and providing that the Council of the College might require the applicant to take the final year course in a Canadian medical school. The "Two-year Internship, Six Basic Science Subjects" rules for "qualified approval" medical schools were introduced between 1952 and 1957.

³⁶Yet, as we shall see in a moment, that is precisely what is being denied (as a result of recent amendments to the Regulations) in the case of certain of these doctors who opt for specialty training in Canada in two specialties (paediatrics and internal medicine).

In the past, although such applicants could be licensed on the Educational Register, they were advised that they did not qualify for full licence. They could be considered for restricted licence on the Special Register for institutional posts, and there was provision that "if they proved highly competent" they might be granted full licence as an act of grace. As a result of much pressure, the College relaxed its position somewhat and in April 1967³⁷ introduced new regulations. The position now is that a graduate of a school that is recognized by WHO, but whose degree is not acceptable for full registration in Ontario, may "work his passage" in one of two ways. Either, he may take the last two years of the professional course in a Canadian university *and graduate in that university* (i.e., he must "go back to school"), after which he must interne for a year and pass the MCC examinations; or, he may take at least two years of specialty training in a university-affiliated hospital or hospitals in Canada,³⁸ receive "an unqualified recommendation" from the appropriate heads of department responsible for his specialty training program, and obtain certification by the Royal College of Physicians and Surgeons of Canada (see Chapter 9).³⁹ It should be noted that this alternative applies to specialization in internal medicine and paediatrics only.

Registration *on the Special Register only* may be granted to a graduate of one of these schools if his Royal College specialty qualification is in pathology, radiology or physical medicine.⁴⁰ The person so registered *must* hold a geographic full-time appointment in an Ontario hospital, and his practice is limited to his specialty in accordance with the standard practice of the College in such Special Register cases.

General Policy

Although we are anticipating the discussion of specialty training in Chapter 9, it is desirable to point out here a strange anomaly that has arisen as a result of differences of opinion between the Royal College and the Ontario College about "acceptable medical schools". As we shall see in the next chapter, in order to qualify for entrance to the Royal College examinations the candidate must have a degree from a medical school approved by the College, *but he need not possess a licence to practise medicine*. The Royal College's list of approved schools and that of the Ontario College do not coincide. The Royal College policy, in principle at least, is that they "will accept a medical qualification that will provide (to the holder) full registration for the practice of his profession in

³⁷After the Committee on the Healing Arts began its deliberations.

³⁸Research and clinical fellowships are not accepted as part of this two-year training period.

³⁹He must then, of course, pass the MCC examinations, and so on.

⁴⁰This, again, was in large part a response to pressure, in this case from specialties that were seriously undermanned. It is proposed to add psychiatry to the list.

the country in which he obtained his qualification".⁴¹ As a result of the rather confused state of the licensing regulations in Canada generally, foreign doctors applying for hospital posts and/or licensing have not infrequently had their application referred to the Royal College by the provincial licensing body for an opinion as to their acceptability. The provincial licensing authorities' argument has been that if the Royal College will accept the doctor, then they will also. This is a most unsatisfactory state of affairs, for it is an attempt to put the onus of a licensing decision on a non-licensing body. It appears that some applications have even been made by doctors who had no intention of ever taking a specialist qualification but merely wanted a piece of paper saying that their credentials were acceptable to the Royal College. It is not known to what extent this practice has arisen in Ontario; but it in no way alters the fact that, as things stand at present, it is quite possible for a man from a medical school that is not acceptable to the Ontario College to obtain a Royal College qualification (in a specialty other than internal medicine or paediatrics) and be unqualified for full licence in Ontario (indeed a number of the "Asian doctor" cases have turned on precisely this point). It is also quite possible for a man to qualify in certain specialties and be unqualified even for registration on the Special Register.

The College has always argued that full licensing means that the holder is qualified to practise general medicine, and that a specialty qualification should not be permitted to become a back door to general practice for the foreign doctor with a below Canadian standard M.D. Internal medicine and paediatrics have recently been exempted from the general rule because it was felt that these specialties were close enough to the requirements for family practice to make this possible. Those certificated in other specialties are considered on their merits. For example, an Egyptian graduate with certification in general surgery who has had at least two years of his specialty training in university-affiliated hospitals in Canada, and for whom unqualified references are forthcoming from the appropriate heads of department, could be granted an Enabling Certificate and after passing the MCC examination would be entitled to full registration. We under-

⁴¹Transcript of a closed meeting, Committee on the Healing Arts and Royal College, November 13, 1967. The witness added the qualification: "That is a generality. There are certain schools about which it is very difficult to obtain information . . . for instance, Chinese medical schools" The witness was then asked: "How is the public to understand that a man may be qualified enough to obtain his fellowship or certification and yet not be qualified to practise medicine in the province?" The answer, emerging later in the discussion, was (in brief) that, by that time, the man has done up to five years specialty training. In other words, the Royal College accepts the man *for* training; it does not agree *ab initio* that he has a right to practise. This argument appears to the writer to be acceptable so far as it goes — but it does not dispose of the anomalies cited in the text. The basic dilemma has been the lack of uniformity in licensing requirements on the part of the provincial licensing bodies, a fact that they have now apparently accepted and intend to rectify.

stand that there have been several cases of this sort.⁴² On the other hand, those who have not had the necessary specialty training in Canada or the United States, or whose references leave something to be desired, may be rejected outright or may be required to have a further period of prescribed hospital experience on the Educational Register.

In the case of the Special Register, pathology, radiology and physical medicine were excepted because (generally speaking) they can be practised only in a hospital. The College states:

In special circumstances, which are hard to specify, one of the other clinical specialties might be registered on the Special Register, but up to the present this has not occurred. If the applicant is not considered fit for full registration it has been difficult . . . to define a situation that would warrant placing him on the Special Register.⁴³

There is little doubt that serious anomalies now exist. (Moreover, considerable delays sometimes occur in informing applicants about their acceptability.) We were encouraged to learn that this view is shared by the College. The Regulations are "in a very fluid state",⁴⁴ and the Registrar has indicated that more precise ground rules should certainly result from the review that is currently being undertaken by the Federation of Provincial Licensing Authorities. This review is aimed at bringing about a greater measure of standardization from province to province.

The current proposal appears to be to divide medical schools into three generally agreed lists.⁴⁵ The first of these would include all the medical schools at present fully accepted by the Ontario college — namely, those of Canada and the United States, the U.K., Eire, Australia, New Zealand, South Africa and Jamaica (University of the West Indies). The second list has yet to be drawn up, but graduates of these schools would have to meet the following additional requirements before licensing:

- 1) A screening examination — either ECFMG as at present, or some other of equivalent or higher standard. ECFMG received a vote of

⁴²Private communication, Registrar of the Ontario College and the author, April 1, 1968. The College of Physicians and Surgeons of British Columbia has recently reduced its requirements to *one* year of residency in such cases, but it is not clear whether or not they would be prepared to grant a *full* licence, as the Ontario College evidently would (see *Medical Post*, November 7, 1967).

⁴³*Ibid.*

⁴⁴*Ibid.*

⁴⁵The American position is as follows: the AMA has discontinued its list of Approved Foreign Medical Schools. It recognizes as eligible for internship and residency training a graduate of any foreign medical school if he has been certified by ECFMG. *However, each State in the Union has the right to recognize only those schools that it considers qualified*, and some States do have their own lists of approved schools. In addition, each State may have such other requirements as a specified period of internship and residency training in an approved hospital, and certification by its own State board of medical examiners.

confidence, and it was considered that the cost of setting up a separate Canadian screening process was not justified.⁴⁶

- 2) A basic science examination conducted by the Medical Council of Canada "or other Canadian agency acceptable to the Federation".
- 3) Two years' internship: one year to be taken in an approved Canadian hospital and the second in an approved Canadian hospital *or* an American hospital affiliated with a university, one of the two years to be a rotating internship.

A Committee was appointed at the first meeting of the Federation in February 1968 to prepare proposals for schools to be included in Lists One and Two. Schools not accepted for either of these lists (and it appears to have been the majority view that there would be some) would be consigned, as at present in Ontario, to List Three for whom, however, a new set of common requirements would be developed.

It may be of interest to note some of the complications that have arisen in applying the regulations (these instances are taken from a scrutiny of a very limited sample of cases put at our disposal by the Registrar of the College). One applicant, a graduate of the University of Budapest, was granted an Enabling Certificate but, on failing the MCC examinations seven times, was finally denied a licence. A Yugoslav graduate who had passed the ECFMG examinations and the basic science examinations was denied an Enabling Certificate to write the MCC examinations pending satisfactory completion of a rotating internship. This action was taken because several of the reports on the doctor's interne year indicated a lack of interest. This woman was a highly competent specialist, but she was simply not interested in the interne year. One doctor, born in Ghana, a graduate of the University of Geneva, holding a Bachelor of Medical Science degree from the University of Fribourg and having registration with the U.K. General Medical Council, failed the ECFMG examinations four times, was granted an Enabling Certificate in Nova Scotia and passed the MCC examinations. He protested the requirement of the Ontario College that he pass basic science examinations on the ground that it was nine years since he had done any basic science. When he did write them, he failed in one paper; but by agreement between the College and the senior examiner, was allowed a special rewrite and was finally granted a full licence to practise in Ontario. This case

⁴⁶Quebec has its own screening for French-speaking doctors from abroad but uses ECFMG for English-speaking applicants. It should be noted that the "vote of confidence" was in the ECFMG as a screening mechanism only; it was not accepted that it should convey any right to practise. A Canadian screening mechanism for all immigrant doctors was proposed by the President of the CMA in 1967 and endorsed by Mr. Marchand, the Minister of Manpower and Immigration, in an address (by proxy) to the CMA at its Centennial meeting. There appears to be a slight difference, however, in the two proposals. Dr. Thomson called for the screening of medical immigrants, whereas Mr. Marchand talked about the screening of medical *schools*.

apparently took three years from the time of the initial inquiry to the College until the advice that he was eligible for full registration.

Several points of interest arose in the course of this inquiry into licensing practice. One was that the ECFMG examination sometimes proves difficult because the candidate is not used to the multiple-choice type of test. (The test in English is, of course, another common stumbling block.) It appears that the Government of India will not allow the ECFMG examinations to be written in India (a move no doubt aimed at keeping her medical graduates at home). It is also said that the countries of origin sometimes try to prevent the granting of landed immigrant status, without which the applicant cannot even be considered in this province.

The Licensing Issue

The debate about the "foreign doctor issue" has been acrimonious at times and has generated considerable emotion on all sides. The peculiar problem that it poses for licensing authorities such as the Ontario College may be gauged from Table 3, which shows the approximate number of doctors by country where the first medical degree was obtained who were on the Ontario Educational Register in 1966. This table illustrates very vividly the extraordinary range of countries and the diversity of social and cultural backgrounds from which foreign doctors now come.

Table 4 shows how Ontario compares with the other provinces in reliance on foreign sources. The table gives the actual number of foreign doctors (all categories, including Britain) *registering* in each province in the years 1961 through 1964, and expresses this number as a percentage of *all* new registrants in each of those years. Table 5 separates out the British-trained element in this. It will be noted that Ontario consistently registers proportionately far fewer foreign graduates each year than do any of the other provinces except Quebec, where special considerations apply. In 1964, three-quarters of all the newly registered doctors in Newfoundland and Saskatchewan came from outside Canada, whereas less than one-fifth of those registering in Ontario did. In that year more than half the new registrants in Saskatchewan and a quarter of those in Manitoba were British-trained, compared with 13 per cent in Ontario.

Table 4 shows also the steady decline in the number and proportion of foreign registrants in Ontario in each of the four years up to 1964; the proportion of British-trained registrants, however, has remained relatively steady.

The "foreign doctor problem" appears to revolve, essentially, around three main issues: the shortage of doctors and how best to try to overcome it; the "human rights" issue; and the problem of protecting the public against the lowering of standards. These issues are all interconnected.

TABLE 3

Approximate Number of Doctors on the Ontario Educational Register
by Country where First Medical Degree Obtained, 1966.

CANADA (401)		OLD COMMONWEALTH (16)	
Ontario	337	South Africa	8
Other Provinces	64	New Zealand	4
		Australia	4
UNITED STATES	8	MIDDLE EAST (27)	
		Turkey	8
UNITED KINGDOM	85	Lebanon	2
		Egypt	9
		Iraq and Iran	7
EUROPE (68)		Israel	1
Greece	5	ASIA (133)	
Yugoslavia	4	India	84
Italy	4	Taiwan	23
Spain	14	Japan	3
Ireland	14	Thailand	6
Holland	4	Korea	5
Switzerland	4	Pakistan	8
Germany	4	Indonesia	1
Austria	2	Manchuria	1
France	1	Hong Kong	1
Hungary	2	Afghanistan	1
Poland	6	SOUTH AND CENTRAL AMERICA (16)	
Portugal	1	Mexico	1
Rumania	2	El Salvador	1
Lithuania	1	Peru	3
PHILIPPINES	60 (?)	Brazil	3
		Uruguay	1
WEST INDIES	6	Colombia	5
		Venezuela	1
AFRICA		Haiti	1
Nigeria	1		

SOURCE: Our own count. Subject to considerable error in detail, but the table shows approximate orders of magnitude.

TABLE 4
Foreign Registrants by Province
1961-1964

(As a Percentage of All New Registrants)

Province	1961		1962		1963		1964	
	No.	%	No.	%	No.	%	No.	%
Newfoundland	54	86	45	87	35	81	33	75
Prince Edward Island	0	0	1	50	5	100	1	33
Nova Scotia	24	44	22	36	29	53	37	47
New Brunswick	—	—	—	—	—	—	—	—
Quebec	45	14	52	16	47	14	52	15
Ontario	113	28	101	26	85	22	77	19
Manitoba	48	52	49	55	64	63	71	65
Saskatchewan	55	64	145	86	117	82	108	75
Alberta	59	44	77	54	59	42	73	58
British Columbia	46	34	57	42	34	28	55	44
Canada	444	35	549	40	475	36	507	36

SOURCE: OMA, Supplementary Brief to the Committee on the Healing Arts.

TABLE 5
British-Trained Registrants by Province
1961-1965

(As a Percentage of All New Registrants)

Province	1961		1962		1963		1964	
	No.	%	No.	%	No.	%	No.	%
Newfoundland	36	51	27	43	21	40	20	36
Prince Edward Island	0	0	0	0	4	80	0	0
Nova Scotia	19	35	18	30	23	42	27	35
New Brunswick	—	—	—	—	—	—	—	—
Quebec	3	1	11	3	5	1	16	5
Ontario	48	12	48	12	55	14	52	13
Manitoba	31	34	20	22	25	25	28	26
Saskatchewan	31	36	123	73	80	56	74	54
Alberta	39	29	56	39	41	29	53	42
British Columbia	31	23	35	26	24	20	31	19
Canada	238	54	338	62	278	59	301	59

SOURCE: OMA, Supplementary Brief to the Committee on the Healing Arts.

The problem is not, of course, confined to Canada, let alone to Ontario. In Britain the shortage is compounded by a sizable exodus of British-trained doctors to other countries, chiefly Canada and the United States,⁴⁷ and it is widely recognized that in some areas of the country and in some hospitals the National Health Service would be in danger of collapse were it not for the immigrant element. There are said to be from 3,000 to 4,000 "coloured doctors" in Britain today, a great many of whom go there in the hope of doing postgraduate work. For the majority, perhaps, that hope is soon frustrated.

An Indian doctor who arrives, as most of them do, with only a few pounds, and has to get a job immediately, finds himself in a dilapidated infirmary in a mining valley or a steel town. This is unlucky for him but fortunate for the Health Service, which, like the railways and the buses, would be in trouble without immigrants. A quarter of the junior doctors in Britain are coloured, but they are not evenly distributed. Some hospital regions in the North of England have as many coloured as white doctors; I went to a Welsh hospital where eleven out of fourteen were coloured. "Everything is done to dissuade them from getting a higher qualification", said a consultant — white — who is on their side⁴⁸

In the United States the situation exhibits some marked similarities.⁴⁹ There are now approximately 11,000 foreign medical graduates in approved internships and residencies in American hospitals; and, at a time when the hospital is becoming more and more the focal point of medical care, approximately one house officer in every four (excluding Canadians) is educated outside the country. In New York and New Jersey foreign medical graduates represent 50 per cent to 75 per cent of the total house staffs. Community hospitals in many areas are completely dependent on them to meet the need for internes. And, as in Britain, the F.M.G. is used, more often than not, as sweated labour: "as cheap help in community hospitals that cannot attract American medical graduates".

. . . professional services are frequently provided by physicians who have limited knowledge of English and have been educated in institutions that we cannot evaluate accurately and about which we know very little. Even though all F.M.G.'s who come here have performed satisfactorily in the examination of the . . . ECFMG, some characteristics are difficult to assess, and we do know there are very few medical schools abroad, including those in Europe, that even approach our standards for medical education. Graduates of these schools may be given heavy responsibilities almost immediately on their arrival here, and no adequate study has been made of the impact of this practice on the quality of hospital care.

⁴⁷Some details about emigration from Britain are given in an appendix to Chapter 13.

⁴⁸Paul Ferris, *The Doctors*, Penguin, Harmondsworth, 1967, pp. 68-69.

⁴⁹The facts and quotations that follow in the next few paragraphs are taken from an article by Dr. Harold Margoulies, Associate Director, Division of International Medical Education, Association of American Medical Colleges: "The Foreign Medical Graduate in the United States", *Journal of Medical Education*, September 1966.

The author continues:

Unless one is willing to equate success by examination alone with graduation from an approved American medical college in addition to examination—and few would be willing to do so—there is reason to be deeply concerned with the effect of thousands of imported physicians on the quality of American medical care Most F.M.G.'s have been taught primarily by lectures in institutions that have highly inadequate laboratories, libraries and hospital facilities.

. . . we long ago abandoned the system under which physicians were allowed to practise medicine following apprenticeship if they could pass the tests for licensure. In the case of foreign medical graduates we have virtually reverted to that obsolete device. Inadvertently, we in the United States have established two standards of medical practice.

In its advice to Americans who may be contemplating medical studies abroad, the Association of American Medical Colleges asserts that foreign medical schools fall into three categories: schools that have standards that are much the same as those in schools in the United States and Canada, in which the criteria for admission are high and from which most students graduate; schools with admission standards that are lower, but whose scholastic standards remain high, with a high failure rate, and whose graduates therefore have little difficulty in passing the ECFMG examinations; and schools that admit too many poorly qualified students and graduate too many of them, and whose graduates have, in consequence, a high failure rate in the ECFMG examinations. Apparently, a substantial number of Americans attend medical schools in Italy, Mexico and Spain,⁵⁰ and most graduates of these schools have great difficulty in passing the ECFMG, the overall pass rate ranging from 16 per cent to 30 per cent (even fewer the first time). But the majority of these graduates, of course, were previously rejected by American schools and for the most part had low MCAT scores.

The position taken by the Ontario College of Physicians and Surgeons, though somewhat less rigorous than that of the Association of American Medical Colleges, is in substance the same. At the height of the "foreign doctor" controversy in Ontario the then President of the College, Dr. D. L. Wilson of Queen's, made a statement to the press, a more detailed version of which was later published in the *Ontario Medical Review*.⁵¹ Dr. Wilson pointed out that, between 1953 and 1964, the College granted enabling certificates to 480 graduates from acceptable foreign medical schools and 430 of them passed the MCC examinations: 89.5 per cent as compared to 95 per cent for graduates of Canadian medical schools. This success rate of 89.5 per cent "by candidates who were carefully screened by the College" was related to the 40 per cent success rate by candidates receiving enabling certificates from *all* ten provincial colleges. This comparison, Dr. Wilson argued, "would appear to demonstrate that the (College) has achieved a con-

⁵⁰No details were given of the ethnic origins of these Americans—i.e., how many were drawn from minority ethnic groups.

⁵¹*Ontario Medical Review*, September 1965 and October 1965, pp. 634 and 700.

siderable degree of success in its efforts to determine the foreign medical schools that provide a qualification equivalent to that provided by Ontario medical schools".

This is a somewhat specious argument, for it conceals the fact that the success rate is artificially boosted by the presence in the sample of a large proportion of British-trained candidates. If we look at the MCC results in 1964, for example, 95.4 per cent of Canadian graduates passed all papers in the MCC examination at their first attempt, compared with 84.9 per cent of British and Irish candidates, and 41.9 per cent of foreign candidates. At the same time, it is perfectly true that the "pass-first-time" rate for foreign graduates is remarkably low (many, of course, pass at subsequent attempts). The pass rates for selected countries over the period 1919-1963 are as follows (rates *including 1964* are shown in brackets):

Canada	92.4%	(92.4)
U.K.	87.4	(87.4)
Ireland	73.4	(72.4)
U.S.A.	66.6	(66.3)
Austria	54.3	(53.5)
France	73.8	(73.6)
Germany	55.6	(55.7)
Hungary	50.6	(50.2)
India	76.4	(75.7)
Italy	44.7	(44.1)
Poland	47.3	(46.6)
Philippines	41.2	(43.3)
Switzerland	66.3	(66.3)
Spain	45.5	(45.9)

Since these are the figures frequently used by human rights organizations to support their case on behalf of Asian doctors, it should be pointed out that the Indian 1919-1963 percentage is based on a population of only fifty-one candidates,⁵² compared with the Canadian percentage, which is based on a population of 19,231 (U.K. 1,656; Ireland 244; Hungary 413; Italy 190). This is not to say, of course, that if more Indian graduates had been allowed enabling certificates they might not have done as well: but the figure is based on a group of candidates that were drawn from the older established Indian medical schools. The College's case is that there has been an enormous expansion of Indian medical schools (chiefly since Independence) — from twenty in 1947 to seventy-one in 1963 — an incredibly rapid expansion which, according to the College, "has had a catastrophic effect on the quality of Indian medical education". Even so, the figures

⁵²However, the rate *including 1964* (i.e., 1919-1964) was based on a population of eighty-four (some thirty candidates having sat the examination in 1964); thirty-three more sat the examinations in 1965, with a passing rate of 78.9 per cent. It is notable that the candidates continue to be drawn from the older established schools, such as Bombay, Calcutta, Madras and Lucknow.

suggest that the College should be more selective in its screening of overseas medical schools and should avoid blanket condemnation of *all* schools in a given country. It is to be hoped that in the current reassessment of the situation the Federation of Licensing Authorities will revise its policy. (It has been quite properly pointed out to us by one of the human rights organizations that the Indian doctors concerned in the recent controversies received their original medical education before the expansion of Indian medical education began. The College has perhaps been unwise in trying to rely on retroactive arguments.)

It is worth noting, incidentally, that in 1968 there were more Indian doctors on the Educational Register in Ontario than sat the MCC examinations *from the whole of Canada* in the entire period from 1919 to 1963.

One of the arguments of the critics is that the passing of the MCC examinations should be a sufficient test of the candidate's proficiency. The College's answer to this is that it totally misrepresents the role of formal examinations in the Canadian system of medical education:

A medical school awards its M.D. degree to a student on the basis of his completion of *all* the undergraduate training requirements of its curriculum and his successful passing, not only of his final examinations, but of a formidable number of formal and informal tests and hurdles along the way No respectable school would allow a man who had not submitted to its courses of instruction to write its examinations and then grant him an M.D. degree if he passed.⁵³

And further:

. . . the examinations of the Medical Council of Canada are not in fact used to screen even Canadian graduates, except in the most superficial sense Some 95 per cent of Canadian graduates pass "the Councils" on their first try, and the remainder almost invariably pass the supplemental examinations. Scarcely any one has been screened out from practice by these examinations in living memory. Among the foreign medical graduates, the failure rate is very much higher.⁵⁴

Most, however, eventually pass, perhaps after repeated tries (we have already noted, incidentally, that repeated tries are *not* allowed in the basic science examinations); but only, in other words, after a prolonged period of internship on the Educational Register and under Canadian medical supervision.

This is a plausible argument, though it does seem to call in question the value of the MCC examination for the graduate of an "approved" school such as the British doctor.⁵⁵ Dr. Wilson's point is that "the Councils" serve a useful purpose "mainly in checking the standards of training in our medical schools one against the other Were it not for this function . . . I suspect that it would have been

⁵³Dr. Laurence Wilson, article in *Ontario Medical Review*, *op. cit.*

⁵⁴*Ibid.*

⁵⁵Or the U.S. doctor — or, come to that, the Canadian trained in an American medical school.

abandoned long ago." One cannot escape the feeling, however, that the MCC examination is no longer essential either for Canadian or "approved school" foreign candidates, and that it is mainly vested interest and historical momentum that keeps it in use. It poses little hardship for the young Canadian graduate since he normally takes it conjointly with his finals. The only possible value it has for the British doctor is that it forces the older man to bring himself up to date; but that argument might well apply to the older Canadian doctor too. Indeed, there may well be something to be said for a periodic "relicensing" examination of this sort for *all* doctors in Ontario regularly engaged in practice outside a hospital.

The Ontario College is often unfavourably compared (i.e., for its rigorous standards) with the General Medical Council in Britain, a body of international repute. The facts are set out briefly in an appendix to this chapter on licensing in the other nine provinces, Britain and the United States; therefore there is no need to dwell on them here. Suffice it to say that the situation has been somewhat misrepresented and that the differences between the two bodies are by no means as great as is sometimes alleged, *at least in so far as they relate to general or family practice*. Both British and American practice seem to have been more liberal in admitting foreign doctors *to limited practice in the hospital*; but whether the results are in the public interest, or in the real interests of the foreign doctor, is another matter.⁵⁶ This requires further study; but some hints were provided earlier (we should perhaps regard them as unconfirmed hypotheses) in the quotations from Ferris and Margoulies. The question is a difficult one, and it raises, though obliquely, the whole issue of the reality under modern conditions of the concept of the "full" licence to practise any form of medicine: to be specific, is the "full" licence any longer realistic? or should we move to a "limited licensing" situation in which *all* doctors would be licensed to perform *only specified types of medicine*, perhaps including family practice — substantially redefined, and no longer coincident with "general practice" — as one of these types?

On one issue there is no doubt, and that is the charge of racial discrimination. There may be racial discrimination in Ontario medicine; but it is not apparent in the licensing regulations themselves, which (as we have seen) discriminate against medical schools on the basis of their quality, not against doctors on account of their race or nationality. A Canadian national who graduated from one of these schools would be on exactly the same footing as a national of the country concerned, just as the United States graduate of a Mexican medical school will find himself disadvantaged in competition for licensing with a graduate of an American school.

⁵⁶Especially since, as Dr. Margoulies points out, the hospital is rapidly becoming the focal point of medical care. A related question, though one that is strictly outside the terms of this report, is whether it is in the interests of the underdeveloped countries that their best medical graduates should be encouraged to emigrate, and even whether the type of medical training they receive in Western countries is a realistic training for work in their own countries if they decide to return. Where is a Nigerian doctor best trained, for example: at the Middlesex Hospital, or at Ibadan?

The available statistics indicate that over 90 per cent of medical immigrants to Canada are eventually licensed. A very high proportion of these are from Britain, because their schools are generally accepted and six provinces have reciprocity with the General Medical Council. Since 1960 foreign-trained doctors have formed about 40 per cent of total licensees in Canada. In many provinces the proportions are much higher, and it is Ontario and Quebec that have held down the national average. This would seem to be a clear indication that Ontario should reconsider its policy in relation to reciprocity with the General Medical Council and abolish the requirements that British-trained immigrants (who may well, of course, include some doctors of Asian and other origin) should take the MCC examinations. The available figures (which are not strictly comparable)⁵⁷ suggest that about a third of the licensees from British medical schools since 1960 were originally nationals of other countries. These would include foreigners who trained in British medical schools, returned home and then emigrated from their own countries, as well as foreigners who emigrated directly from the U.K.

In 1965, the College released some statistics about the distribution of foreign doctors practising in Ontario (excluding U.K., U.S. and "White Commonwealth" doctors). Fifty-three per cent were practising in Metropolitan Toronto; 15.7 per cent were located in four other communities over 100,000; 8.8 per cent in five communities of 50,000 to 100,000; 6.1 per cent were practising in seven communities of 25,000 to 50,000; and 1.3 per cent in two communities of 5,000 to 25,000. Only 15 per cent were located in communities under 5,000. In three communities under 5,000 there were six such doctors, comprising 85 per cent of the practitioners in those areas.

When we visited Parry Sound we found that, of the twelve doctors in the town, four had come from Britain and one was an Egyptian who had done his training in Britain. In spite of such instances, however, the statistics give little comfort to those who see the immigrant doctor as a solution to the maldistribution problem (the problem of attracting doctors to the remoter parts of the province). On the contrary, and not very surprisingly, the immigrant doctor, like his Canadian counterpart, would seem to favour practice in the larger cities and metropolitan areas. Foreign medical graduates now make up about 7 per cent of the local doctor population in Metro Toronto, 4 per cent in cities of 50,000 to 250,000, 6 per cent in communities of over 5,000.

None of the Medical Acts of the Canadian provinces requires the provincial licensing authority to concern itself directly with manpower problems — that is to say, with maintaining an adequate number of doctors in the province. Nor are the medical schools expected to assume this role. The responsibility for it rests, if it rests anywhere, with the provincial governments. On the other hand, every provincial licensing authority makes regulations for the licensing of physicians in its

⁵⁷Figures supplied by the OMA in its supplementary brief to the Committee on the Healing Arts.

own province; and the manner in which the regulations are framed will clearly affect the internal manpower situation, as will the admission and academic requirements of the medical schools. At the Centennial meeting of the CMA in Montreal in June 1967, Dr. Bramley-Moore of the Medical Council of Canada (and Registrar of the Alberta licensing authority) put forward the suggestion that licensing should (in essence) be nationalized: that is to say, that provincial licences to practise medicine (i.e., general or family medicine) should be issued automatically on passing the MCC examinations, and that licences to practise a specialty *only* should be granted automatically on obtaining the certification of the Royal College. At present there is no licence (as such) to practise a *branch* of medicine (see Chapter 9). One implication of Dr. Bramley-Moore's comments, then, seems to be a standardized and limited licensing for the specialist and family doctor alike.⁵⁸ A further implication is that the screening of medical schools should be centralized in the hands of the MCC and the Royal College.⁵⁹ Both these suggestions make good sense, but the creation of the Federation of Licensing Authorities implies that they are not fully acceptable to the licensing bodies themselves. Dr. Bramley-Moore suggested that in return for an apparent diminution in the scope of their work, the provincial licensing authorities should, in future, take more responsibility for medical manpower and recruitment to the profession.

Hospital Privileges

The question of hospital privileges is equally important for the specialist, the general practitioner and the patient. It is important for the specialist because hospital practice, in most specialties, is the life-blood of his work. It is important for the general practitioner because a large-hospital appointment helps him to keep in touch with the single most important centre of medical practice today; and even a small-hospital appointment allows him to meet his fellow doctors in a professional environment and to continue to attend to his patients' care. And it is important for the patient because, if his doctor is not a member of a hospital staff, he cannot get him into hospital (except by referral);⁶⁰ and, unless the doctor is a member of the *attending* staff, he cannot continue to care for the patient when he is admitted.

We have noted the general principles of hospital staff organization and hospital privileges in Chapter 5. In the large departmentalized hospitals, the head of

⁵⁸He said he believed that "if the licensing authorities, universities, and the College (of Family Physicians) will properly define the scope of work of the general practitioner we could then proceed with changes which would cause the MCC to examine all persons desiring to enter general practice in any part of Canada."

⁵⁹Dr. Bramley-Moore suggested that the MCC already had the power (under the Canada Medical Act) to take over the work of accrediting foreign medical schools.

⁶⁰As we saw, this is a matter of *law* (the Public Hospitals Act) and not merely of professional practice.

department is in a very powerful position, with the President of the Medical Staff and other medical staff officers acting, so to speak, as shop stewards "watching the management on behalf of the rank-and-file". There is no right of appeal beyond the Board of Trustees for any aggrieved G.P. or specialist whose application for hospital privileges is refused, whatever the size and nature of the hospital. In the small local or community hospital the applicant (generally a family doctor) is notionally at the mercy of his brother physicians already on the staff; on the other side of the coin, however, the spirit of freemasonry of the profession urges them to accept him if he is at all competent and has something to offer. In the larger hospital, the young specialist applicant may be caught up in the medical bureaucracy or become a victim of the departmental struggle for beds; the general practitioner applicant may be admitted for outpatient and emergency department work (including some minor surgery) without difficulty, and then find that he cannot get his patients admitted because beds are so rarely available.

The "bed question", as it affects general practitioners, is a matter of crucial importance, and it is worth devoting some space to it here.

At the beginning of 1965 the Ontario Chapter of the College of Family Physicians made a survey of general practitioners' hospital appointments by polling about 1,100 of its members. The survey⁶¹ revealed widespread dissatisfaction, particularly among urban doctors. A major complaint was the policy of "blanket restrictions placed upon the G.P. in the hospital without regard to the competence of the individual doctor" (this would appear to refer to the practice of relegating *all* G.P.'s to certain categories — for example, emergency and outpatient work only; the competence of the individual doctor *is*, of course, taken into account when considering his application). The relationship between the G.P. and the specialist in the smaller hospitals was said to be "usually good with generally satisfactory rapport". Among the reasons cited for this were the numerical superiority of the G.P.'s; the greater dependence of the specialist on them for referrals; and the larger representation of G.P.'s on medical staff committees. Exclusion, or at best "tolerant admission to restricted facilities", was the lot of the urban G.P., particularly in downtown metropolitan areas. This was accentuated in the teaching hospitals, where the shortage of non-clinical teaching beds was an added factor.

The competition for admission of patients to hospital is great and weighted heavily in favour of the specialists as most serious cases and extreme emergencies have priority. There is reason to believe that if there were an excess of empty beds the Board of Directors of the hospitals would welcome more admissions by G.P.'s and likely act to relax restrictions imposed by the specialty staff.⁶²

⁶¹Reported in the *Journal of the College of General Practice of Canada*, February 1966, p. 38.

⁶²*Ibid.*

The report goes on to say that a considerable number of doctors in urban areas show no interest in acquiring additional privileges,⁶³ partly because of the existing workload, but partly also because of repeated discouragements in attempting to get beds for their patients.

It is alleged (though it is virtually impossible to document this) that, in many areas, the degree of exclusion of general practitioners is closely related to the severity of competition between them and the local specialists. What seems certain is that the problem is most acute in areas (as diverse as downtown Toronto and a town like Kingston) where the "local" hospital is also a teaching hospital. It is here perhaps, above all, that the pressure to exclude the G.P. is greatest. In central Toronto, when a patient can get a family doctor at all, there may be no chance (short of referral) that he can get a hospital bed when he needs one. There is little question that the virtual exclusion of the general practitioner from hospital privileges in large metropolitan areas is a factor making for an artificial distortion of the distribution of doctors, since some at least feel driven to move elsewhere, where privileges (such as those of admitting patients) are more readily available. Alternatively, it may lead general practitioners to seek to establish their own hospitals, as in the case of Doctors' Hospital in Toronto.

The pressure to exclude the general practitioner is one of the major reasons for the current agitation to create Departments of General Practice.⁶⁴ Yet such departments work best where the G.P. is in a relatively strong position already. The Department of General Practice at Kingston General Hospital and at the Kingston Hotel Dieu Hospital, for example, are weak. This is mainly the result of opposition from the medical school. A weak Department of General Practice is usually no more than an administrative unit, organizing the work of the general practitioners in the outpatient department and perhaps providing some limited continuing education. It is seldom an active clinical department in its own right. We make further reference to this in a later chapter.

At the Kingston General Hospital, where a brief but sharp public controversy over general practitioners' privileges arose in the first half of 1967, general practitioners are admitted to the associate staff. Attending staff are those with the sole

⁶³One general practitioner, giving evidence to the Committee on the Healing Arts, put it as follows: "Many of us general practitioners are struggling to keep people out of hospital, to do our best for them outside of hospital and this is more of a full-time job. Then, if we are located distantly from the hospital we are not too upset by losing the full management of patients as long as we can have the current care and as long as we can be involved in the hospital program in some fashion . . . something to give us esprit de corps with our compatriots and keep our minds in unison with theirs and keep our desires for academic training at a high level." This doctor was a representative of the Medical Alumni Association of the University of Toronto and would presumably have good contacts with "hospital doctors".

⁶⁴There are, of course, others: such a department may provide the practitioner with a chance to associate with specialists and keep abreast of current techniques, and may give him the resources for research and further education.

right to attend patients in the clinical teaching unit beds — i.e., they are teaching specialists. General practitioners with admitting rights *only* are on the courtesy staff: these are chiefly out-of-town G.P.'s; G.P.'s on the staff of the neighbouring (Queen's Medical School-affiliated) Hotel Dieu Hospital with KGH admitting privileges; and G.P.'s serving a probationary year before being allowed on to the KGH associate staff.

The controversy over the deployment of beds at KGH reflects the difficult position facing a hospital that has to serve both as a teaching hospital for a medical school and as a community or regional hospital for ordinary patient care. As a teaching hospital it is required, as one of the conditions of medical school accreditation, to maintain a certain percentage of teaching unit beds (the minima as currently laid down by the Association of Canadian Medical Colleges are ten beds per final year student, and one new ambulatory — outpatient, emergency — patient a day per final year student). As we have already noted, the main factor limiting the intake into the Queen's medical school is the shortage of teaching beds.

As a community hospital KGH is supported by the community and governed by a board of community leaders, many of whom feel that "their" doctors should be allowed to practise in it. The present emphasis, however, is to sacrifice the general practitioner on the specialist and teaching staff altar of "exemplary patient care". The specialists on the staff outnumber the G.P.'s by more than two to one. They also determine the size of the "opposition" (i.e., the number of G.P.'s allowed on the staff) because it is they who decide on privileges. The applicant's credentials go to the Credentials Committee (which, as it happens, had in 1967 a G.P. as chairman⁶⁵), the members of which are usually all specialists. The recommendation of the Credentials Committee goes to the MAC which is dominated by specialists, chiefly heads of departments. If the G.P. is refused privileges, there is very little he can do about it (when asked about this, the Chairman of the Medical Advisory Committee replied that the doctor could always move to another district).⁶⁶

At KGH any recommendation from the Medical Advisory Committee suggesting changes in the allocation of CTU beds requires the assent of a majority of the voting members of the medical staff present at the meeting (courtesy staff G.P.'s have no voting rights). The controversy over the reallocation of beds at KGH started with such a recommendation by the MAC to a meeting of the

⁶⁵President of the Medical Staff (the President is not usually a G.P.).

⁶⁶In fairness to this gentleman (a paediatrician) it should be added that we formed the impression that he had genuine sympathy for the G.P.'s case in this particular controversy and probably helped their cause a good deal. It was put to us that CTU cases should not be separated from other cases, since these are the cases from which all doctors learn, G.P.'s as well as specialists; and that since the teaching hospitals attract the best men, it is better for the G.P. to work in such a hospital rather than in a G.P. hospital — a proposal that has been made for Kingston by some of the local G.P.'s.

medical staff early in 1967. The proposal would have given the clinical teaching units 70 per cent of the beds, leaving 30 per cent *for the joint use of the attending and associate staff* (i.e., specialists and G.P.'s) and *guaranteeing none* to the associate and courtesy staff alone. Up to this time the CTU's had 300 beds of which 140 were joint user beds and 160 were guaranteed for use by the associate and courtesy staff. The recommendation appears to have come as a complete surprise to the associate and courtesy staff. It appears, also, that no vote was taken at the meeting and the matter was left open for further discussion.

After the meeting, the G.P.'s of the associate staff decided to bring pressure to bear on the MAC and on the Dean of the Medical School (who is widely respected by all doctors but known, nevertheless, for a certain lack of sympathy towards G.P.'s). The assistance of the College of Family Physicians was invoked, nationally and at the Ontario Chapter level, and visits to Queen's and KGH were made by College officials. The press was alerted; the Minister was approached and sent members of his staff to discuss the situation; and the local M.P. and M.L.A. expressed interest, as did members of the City Council (not always, however, in a manner best calculated to help). The result was a modification of the original proposal, accommodating at least some of the G.P.'s grievances and chiefly affecting the medical department, which (along with paediatrics) is the department in which the G.P.'s strongest interests lie. Though far from satisfied and, indeed, deeply suspicious of future developments, the G.P.'s accepted this as the best solution they could hope for in the circumstances.

We have outlined this case briefly, not because it is typical (on the contrary, the fact that KGH is a teaching hospital suggests otherwise) but because it points up rather dramatically the powers of the specialist-dominated medical staff (and particularly of the Medical Advisory Committee) over privileges in the larger hospital.

In his classic work on *The General Practitioner*, Dr. Clute states:

After examining all the evidence available to us . . . we find it impossible to conclude that the charges that general practitioners are excluded from use of hospitals have any basis in fact, so far as (Ontario) is concerned, except, perhaps, in the teaching hospitals.⁶⁷

The phrase "from the use of" is ambiguous, however. It is clear that, when men better qualified in particular aspects of medicine (i.e., specialists) are available, it is in the public interest that the general practitioner should be excluded by the hospital from performing prescribed procedures. The admission of patients without the necessity of referral, and the privilege (or should it be the right?)⁶⁸ of attending his patient in the hospital is, however, quite another matter.

⁶⁷K. F. Clute, *op cit.*

⁶⁸It is notable that in all the debate about hospital privileges, the patient's rights in the matter are seldom voiced, while much is made of his obligation to act as guinea-pig in clinical teaching beds, for example.

Appendix II

Some Notes on Licensing in Other Provinces, in the United States and in Britain

Other Canadian Provinces

Alberta

Reciprocity with the General Medical Council of G.B. and with the National Board of Examiners of the U.S. — i.e., doctors registered on the Home List of the GMC of G.B. and those who possess a Diploma from the NBE of the U.S. need not pass the MCC examinations.

Graduates of the Alberta medical schools are similarly exempt.

All other applicants must pass the MCC examinations before license, and their qualifications are subject to scrutiny to determine whether they are at least equivalent to those required for registration in the province. Those with "sub-standard" qualifications may be further examined.

British Columbia

All applicants for licence must pass the MCC examinations. Graduates of medical schools in Britain, Eire, the U.S.A., Australia, New Zealand and South Africa may receive an enabling certificate to write the MCC examinations provided their postgraduate internships meet the required standards.

European doctors must be graduates of a recognized medical school, must pass the ECFMG examinations, and complete one year's approved internship in Canada before being granted an enabling certificate.

All other doctors must also pass the B.C. basic sciences examinations during their year of internship.

There are certain exemptions for those with Canadian specialist training.

Manitoba

Reciprocity with the General Medical Council Home List, certain Australian and New Zealand universities. Graduates of University of Manitoba medical school also are exempt from MCC examinations.

Graduates from U.S.A. granted enabling certificate to write MCC examinations without further requirement.

Other applicants may be required to pass basic science examinations and serve twelve months in a resident capacity in an approved Manitoba hospital.

New Brunswick

All applicants must pass MCC examinations. Graduates of medical schools in G.B., Eire, U.S.A. may receive an enabling certificate without further requirement. All others, without exception, serve two years in recognized hospitals in Canada, one year of which must be in New Brunswick.

Prince Edward Island

Reciprocity with the Home and General List of the GMC of G.B. Doctors with Australian, New Zealand, South African and Irish qualifications must write the MCC exams after a period of internship in P.E.I. Same for European doctors. Same for doctors from Asia, Middle East, etc.

Saskatchewan

Reciprocity with the Home List, GMC of G.B. (but Apothecaries Hall and L.M.S.S.A. not recognized). Reciprocity with New Zealand, *but not with Australia or South Africa*; graduates of these two countries must pass MCC exams.

Graduates of U. of Saskatchewan exempt from MCC requirement.

All other doctors must pass MCC examinations, and their medical schools must be approved.

The Provincial Medical Boards Examination of the University of Saskatchewan may be substituted for the MCC examination, but, since this qualification is restricted to the province, very few doctors take it.

Nova Scotia

Reciprocity with all lists of the GMC of G.B. All other doctors must pass ECFMG examinations and have completed a year of internship in an approved hospital in Nova Scotia before sitting MCC examinations.

We may summarize, therefore, in the following way. Six of the provincial licensing authorities (Alberta, Saskatchewan, Manitoba, Nova Scotia, Prince Edward Island and Newfoundland, for which further details were not available) have reciprocity with the GMC of G.B. (sometimes with the Home List, sometimes with the Home and Commonwealth Lists of the GMC). British Columbia, Quebec, Ontario and New Brunswick have no reciprocity agreements. One province (Nova Scotia) has complete reciprocity and thus freely admits graduates with a medical education "our College would judge to be inferior" (College

of Physicians and Surgeons of Ontario in a brief to the Committee on the Healing Arts).

It is interesting to note that there is a considerable variation in the composition of the licensing authorities in Canada. Each of the Provincial Acts sets up a Governing Board or Council. In some of the provinces all the members are elected by registered practitioners; in others there are one or more government appointees or *ex officio* members; and in one province there is a majority on the board of persons appointed by the government.

In Prince Edward Island the licensing authority is also the council of the local medical society (i.e., the provincial medical association). The same is true in New Brunswick, though the offices are separate and the Registrar and the Secretary are different persons. In Saskatchewan the two bodies are identical and the Registrar is also Secretary of the provincial association. This is true of Alberta also. In British Columbia the two organizations are different, though they share the same office building. The Registrar and Secretary are different persons. In Manitoba the two organizations share the same office building, but are otherwise distinct.

All licensing authorities have two major responsibilities: the licensing of persons to practise medicine, and the disciplining of members licensed to practise medicine. None of the Medical Acts sets out a responsibility to maintain an adequate number of physicians. All the Acts imply that the licensing authority shall be concerned with the maintenance of a high standard of practice. The Acts vary in the powers they give to the licensing authority in respect to control over educational standards. In some (for example, Quebec) the Act goes into considerable detail; in a few, the licensing authority has no control at all (this rests with the local university).

It is significant that in those provinces that reciprocate with the General Medical Council of Great Britain registration of non-Canadians has exceeded that of Canadian graduates in several recent years. The following are the figures for 1960.

<i>Province</i>	<i>Canadian Graduates newly registering</i>	<i>Foreign Graduates newly registering</i>
Newfoundland	24	83
Prince Edward Island	5	1
Nova Scotia	43	64
New Brunswick	23	7
Quebec	323	36
Ontario	266	135
Manitoba	37	50
Saskatchewan	30	50
Alberta	72	51
British Columbia	99	45

Thus, in 1960, in the "reciprocating" provinces, 211 Canadian and 299 foreign graduates were newly registered. In Newfoundland in particular, however, many of these doctors stay only a relatively short time and then move on to other provinces.

The termination of the reciprocity agreement in Ontario in 1927 is stated by the College to have been due to the fact that "the General Medical Council was unable to consult the parties to the agreement before extending the privileges of reciprocal licensing to the graduates of a number of medical schools whose educational standard was not considered by our College to be up to the Ontario standard".

Britain

The General Medical Council is composed of forty-seven members. Eight, including three laymen, are appointed by the Crown; eleven medical members are elected by the profession in Britain; and the remainder represent the universities granting medical degrees, the Royal Colleges, the Society of Apothecaries, and Apothecaries' Hall, Dublin. There are three branch Councils: for England and Wales, for Scotland, and for Ireland.

Section 18 of the Medical Act 1956 (4 and 5 Eliz. 2, Ch. 76) reads as follows:

Subject to the provisions of this act, any person who shows to the satisfaction of the Registrar of the General Council —

- (a) that he holds some recognized qualification . . . granted in a Commonwealth country to which this Part of this Act applies, or in a foreign country to which this Part of this Act applies, and
- (b) that he is of good character, and
- (c) that he is by law entitled to practise medicine, surgery and midwifery in the country where his said qualification or qualifications were granted,

and who satisfies the requirements of this part of the Act as to experience shall be entitled to be registered

Countries to which "this Part of this Act" applies are specified from time to time by Order-in-Council. A "recognized qualification" is "a qualification recognized for the time being by the General Council as furnishing a sufficient guarantee of the possession of the requisite skill and knowledge for the efficient practice of medicine" In order to satisfy the requirement of "experience", the applicant must comply with regulations as to residency in approved hospitals or other institutions, or equivalent service.

Appeals against refusal of registration lie to the Privy Council (which, unlike the Canadian Privy Council, is separate from the Cabinet: the Privy Council Office and the Cabinet Office are quite distinct institutions in modern Britain).

The Register of the General Council contains the names of fully registered practitioners and provisionally registered practitioners. The former are at liberty to practise at large, while the latter may practise only in approved institutions.

Foreign medical schools recognized by the GMC are listed in the General Medical Register, published annually.

As stated in the text, the GMC policy in respect to foreign graduates is not as different from that obtaining in Ontario as is sometimes thought. One of the major differences has been, precisely, in the policy relating to Indian medical schools. Even here, however, the GMC rejects nearly half the schools. Moreover, as was also pointed out in the text, it is not always easy for the Indian graduate to obtain a post in the National Health Service except as a resident in a hospital, and not always in one of the more desirable hospitals at that.

Thus, though the British policy may appear to be more liberal, its consequences are not always as good as the foreign graduate would wish nor necessarily any better in the long run than those that obtain for him in Ontario. On the contrary, there is considerable evidence that the British medical profession treats the foreign-trained doctor very much as a second-class citizen, though the Health Service relies on his presence to maintain the level of general practice and hospital staffing in the less desirable areas of the country.

The United States

As in Canada, medical licensure is a "state right" in the United States and is entirely within the jurisdiction of the governments of the individual states and territories. The various state boards are the licensing authorities. In addition there is a National Board of Medical Examiners. The intention of the National Board at its founding was to provide examinations of such high quality that legal agencies licensing doctors in the states might do so without further examination. Today all but six states do so. But the National Board examines foreign applicants only on request from a state agency, and each of these has its own policy towards foreign medical graduates. There are several states which either do not license foreign graduates at all, or if they do, they offer only a restricted license such as that offered on the Educational Register in Ontario. Any foreign graduate who passes the ECFMG examination may apply for licensure; but this does not mean he will get it. In 1964, for example, only twenty-seven graduates of Indian medical schools were licensed to practise in the United States, a smaller number, proportionately, than in Ontario in that year. In 1965, forty-one boards required that the foreign-trained physician serve an internship of one or more years in an approved hospital in the United States before being eligible for licensure. In addition, almost all states have a citizenship requirement or a declaration of intent requirement before a full licence to practise can be issued.

Reciprocity with Canada

In 1965, twelve states accepted graduates of approved Canadian medical schools for licensure by reciprocity or endorsement; almost all the remainder accepted them for licensure by examination on the same basis as graduates of approved medical schools in the United States; and the vast majority accepted internship in a Canadian hospital. But most require U.S. citizenship or a declaration of intent to seek such status.

Appendix III

A Note on the History of the College Registers

Until 1941 only one Register and one type of licence existed in Ontario. There are now three: the Register itself, the Special Register and the Educational Register.

The Special Register

In 1941 a temporary form of licence was introduced for medical officers of the British armed forces serving in Ontario. This was replaced in 1944 by a Temporary Register (by an amendment to the Medical Act) and it was intended that it should continue until six months after the end of the war. When this provision lapsed in 1946 the College was left without a means of issuing licences to persons who failed to qualify for inclusion in the Register. Discussions were held in 1958 with the departments chiefly concerned in order to clarify the status of unlicensed physicians in the province, principally those employed by the Government of Canada and serving in the armed forces. These discussions led to the re-establishment of the Temporary Register.

At the same time, the College requested authority to adopt by-laws extending the use of the Temporary Register to doctors in several other categories, including internes in private hospitals, doctors holding professorial appointments and doctors on probation. The request was granted in 1960, and in 1966 the name of the Register was changed to the Special Register. This Register has provided a means by which graduates of approved schools abroad can enter practice in Ontario while waiting to take the MCC examinations; it has been helpful to the medical schools in recruiting distinguished teachers from overseas who might otherwise have been deterred from coming to the province; and it has been useful, too, as a device for handling difficult disciplinary problems where there are special circumstances (for example, in dealing with doctors who have become addicted to alcohol or drugs), or where the question has arisen of readmitting a doctor who has been suspended or struck off.

The Educational Register

This was first established in 1952. A period of hospital experience or internship before practice was common in Canada long before that time; but until 1952 few hospitals required their internes to possess a licence, and few doctors took out licences until they were ready to practise on their own. The growth in the

number of internes not *qualified* to hold a licence led to the setting up of the Educational Register, and teaching and other Group A hospitals were encouraged to have their internes registered. The range of hospitals to which this voluntary arrangement applied was extended in 1956, and (as we have seen) registration of internes became compulsory in 1965. The Educational Register is now used for a variety of purposes, including registration of the quite substantial numbers of graduates of foreign medical schools who are required to make good deficiencies in their medical education before they are granted a full licence to practise.

Appendix IV

The ECFMG Examinations

The Educational Council for Foreign Medical Graduates (ECFMG) was established primarily for the following purposes:

- 1) To promote the advanced study of medicine in hospitals in the United States of America by graduates of foreign medical schools.
- 2) To expand educational opportunities in the United States for graduates of foreign medical schools.
- 3) To serve the public interest by a program of education, testing and evaluation of foreign-trained physicians which will help assure that such physicians are properly qualified to assume responsibility as internes or residents for the care of patients in hospitals in the United States.
- 4) To verify the credentials and evaluate the educational qualifications of foreign-trained physicians who desire to advance their education in the United States; and to arrange examinations to determine the readiness of such individuals to benefit from education in United States hospitals.
- 5) To provide graduates of foreign medical schools with information about training programs, requirements and appointment procedures for residents and internes in United States hospitals, so that they may be able to select programs most suited to their needs.

The candidate for ECFMG certification must have had at least four credit years (academic years for which he has been given credit towards completion of the medical curriculum) in attendance at a medical school that is listed in the World Directory of Medical Schools, published by the World Health Organization. Graduates of schools in the British Commonwealth who hold the diploma of Licensed Medical Practitioner or Assistant Medical Practitioner, or who have other medical qualifications that are not sufficient for registration with the General Medical Council of the United Kingdom, and graduates of similar schools in other countries, are not eligible for ECFMG examination or certification.

The candidate must have successfully completed the full medical curriculum prescribed by the medical school or by the country in which the school is located, and must have received the appropriate university or other acceptable medical qualification. In most countries, the candidate for ECFMG certification must have fulfilled all of the requirements for full and unrestricted licence to practise

medicine (full registration) in the country in which he has had his medical education, and must have obtained the appropriate licence or certificate of registration.

The medical portion of the examination is a written examination of the multiple-choice type, which includes approximately 360 questions in medicine, surgery, obstetrics and gynaecology, paediatrics and the basic medical sciences.

An English test, designed primarily to test the candidate's comprehension of spoken English, must be taken by all candidates taking the medical portion of the examination.

The passing score on the examination is seventy-five. This is not a percentage score, but a scaled score that is related to the scores which have been achieved by American medical students and graduates in the examinations of the National Board of Medical Examiners from which the questions making up the ECFMG examinations have been selected.

TABLE 6

**Number of Foreign Medical Graduates Licensed Annually in Canada
and the United States, 1950-1965**

(Canadian Figures in Parentheses)

Year	Local Graduates	Total Licentiatees
1950	308 (196)	6,002 (1,044)
1951	450 (261)	6,273 (1,163)
1952	569 (339)	6,885 (1,256)
1953	685 (393)	7,276 (1,292)
1954	772 (488)	7,917 (1,421)
1955	907 (447)	7,737 (1,401)
1956	852 (496)	7,463 (1,405)
1957	1,014 (582)	7,455 (1,473)
1958	1,166 (557)	7,809 (1,376)
1959	1,626 (586)	8,269 (1,397)
1960	1,419 (521)	8,030 (1,443)
1961	1,580 (444)	8,023 (1,278)
1962	1,357 (549)	8,005 (1,366)
1963	1,451 (475)	8,283 (1,293)
1964	1,306 (507)	7,911 (1,294)
1965	1,488 (NA)	8,943 (NA)

SOURCES: *Journal of the American Medical Association*, Vol. 196, June 6, 1966, pp. 863 and 872; *Canadian Medical Association Journal*, Vol. 85, November 15, 1961, pp. 1162-1169; and information from the OMA.

Candidates who score seventy-five or higher and pass the English test, and who have completed the documentation of their educational credentials, receive an ECFMG Certificate.

Approximately 10,000 candidates apply each year to take the ECFMG examination for the first time and another 8,000 apply for re-examination after one or more previous failures. The pass rate is 30 to 40 per cent, totalling 7,000 individuals per year, 5,000 of whom take the examination while outside the United States. Of these 5,000, about 300 to 400 are United States citizens studying abroad. Once the candidate has passed the ECFMG he is qualified forever to become an interne in any accredited United States hospital.

Chapter 9 Specialization

*Strait is the gate, and narrow is the way . . .
and few there be that find it.
—St. Matthew, 7:14*

There is nothing in law to prevent the physician, if he wishes, from confining his practice to a particular branch of medicine, and for this he need have no qualification beyond the M.D. In fact, however, he will nowadays be limited in the areas he can choose because many specialties can be practised only within, or in association with, a hospital; and the hospital privileges of the man without a specialist qualification or not actively engaged in seeking one are, as we have seen, very restricted, except in the smaller hospitals in the remoter parts of the province and in the small towns where the general practitioner still tends to be the factotum.¹ (There is a relatively small number of doctors with a specialty qualification from the Royal College of Physicians and Surgeons of Canada who continue as general practitioners, just as there are some specialists who do not have hospital appointments.)

Specialist Training and Hospital Accreditation

The law of Ontario states,² in effect, that the College of Physicians and Surgeons of Ontario shall be the “specialist-recognizing” body in the province. (It “may make regulations providing for a system of classification of legally qualified medical practitioners who because of special training or qualifications are specialists in any branch of medicine, surgery, or midwifery”.) In pursuance of this power, the College is allowed to define the nature of the various classes of specialist it will recognize and to prescribe the qualifications required for each. It is also permitted to “regulate and prohibit the use of terms and designations by medical practitioners indicating specialization”, and the Registrar has power to issue the necessary document to the effect that a particular doctor is or is not so qualified. As we have seen, in practice the College recognizes as specialists in the province only those members of the College in good standing who hold a certificate of specialization or a Fellowship of the Royal College of Physicians and Surgeons of Canada. No doctor may use a specialty designation in Ontario or hold himself

¹For example, at the Tavistock Clinic (a group practice) there are about half-a-dozen physicians: they are all general practitioners but they tend to “specialize” in certain things, such as anaesthetics, cardiology. This is fairly typical of general practice in a small town where the local hospital is extensively, if not entirely, staffed on a part-time basis.

²Medical Act of Ontario, Section 62.

out to the public as a qualified specialist unless he is certificated. Moreover, his recognition as a specialist in the province may be revoked if he has been "censured (sic) or suspended" by the Royal College, or has had his name removed from its lists of Fellows or Certificated Specialists; or if he has been disciplined and found guilty by the Ontario College.³ Conversely, certification by the Royal College carries with it no right, in itself, to practise in the province, whether as a specialist or not; but it is not necessary to be licensed to practise in Ontario *before* taking the Royal College examinations.⁴

Admission to the ranks of the qualified specialists is dependent upon pursuing satisfactorily a period of postgraduate education and training in an approved institution, and passing the examinations of the Royal College. This process involves at least four sets of authorities: the Royal College, the specialist societies, the hospitals and the medical schools. The Royal College and the appropriate specialist society are primarily concerned in defining the scope of the specialty and in prescribing the curricula to be followed. The Royal College accredits the hospital in which the training may be undertaken and formally conducts the examinations. The medical schools have a role to play both in the definition of programs and in the actual training, though (at least formally) they have come on the scene rather more recently than the others. The Royal College has been accrediting hospital training programs for about twenty years. Strictly speaking, it is not the hospital that is accredited, but particular departments within the hospital; and a hospital may be accredited for training in some specialties but not in others. In undertaking this accreditation program, the Royal College argues that it is assuming a moral obligation to the trainees: it assures them that the hospitals it approves are, in fact, capable of offering and maintaining standards of training and experience that will prepare them for the "competent and scientific practice of their specialty" in the future and not merely just enough to get them through a set of examinations. The major responsibility rests (as we saw earlier) on the College's Committee on Approval of Hospitals. The program is quite distinct from the accreditation of hospitals by the Canadian Council on Hospital Accreditation (though the CCHA gives the Royal College some assistance with "on the spot" reviews), and also from accreditation for junior internship training (on first graduation and/or before full licence) which is done by the CMA. It must be distinguished also from the approval of general practice residencies by the College of Family Physicians and from accreditation of the hospital for undergraduate training, which is a function partly of the appropriate affiliating university and partly of the medical school accrediting teams from the Association of American Medical Colleges and the AMA Council on Education and Hospitals. (This multiplicity of accrediting bodies is a matter to which we give some attention later.) The arrangements for which the Royal College gives its stamp of approval

³College of Physicians and Surgeons of Ontario, Warning Notice, 1967, p. 7. For an explanation of the Warning Notice, see Chapter 10.

⁴This has had certain practical consequences, remarked in Chapter 8.

are those for *training beyond the level of the junior internship which is acceptable towards a specialist qualification.*

Such "advanced graduate training", as the Royal College calls it, is taken usually as a resident in a hospital, where the trainee combines postgraduate study with responsibilities, under supervision, for the clinical care of patients; but it may be taken while holding a clinical or research fellowship in an approved hospital or university department. Approval of a hospital department for advanced graduate training is given for one or more years at a time, and for specified numbers of trainees. At March 31, 1966 about forty hospitals in Ontario were so approved for one or more specialties; six of these were Ontario Hospitals (i.e., the mental hospitals) approved for psychiatry only. The breakdown by specialties was as follows:

Specialty	(A) No. of hospitals in province approved by Royal College for training	(B) No. of Toronto hospitals included in (A) in each category
Anaesthesia	20	10
Bacteriology	9	6
Dermatology	5	5
Internal medicine	24	11
Neurology	8	6
Neurosurgery	2	1 ⁵
Obstetrics and gynaecology	17	9
Ophthalmology	12	5
Orthopaedic surgery	12	7
Otolaryngology	8	5
Paediatrics	9	3
Pathological anatomy	24	12
Clinical pathology	19	9
Physical medicine	7	5
Plastic surgery	6	6
Psychiatry	19	5
Diagnostic radiology	20	10
Therapeutic radiology	9	3
General surgery	22	11
Cardiovascular and thoracic surgery	1	1 ⁵
Urology	14	7

In certain cases, group approval is given to the medical school and affiliated hospitals — for example, to the University of Western Ontario for otolaryngology

⁵Integrated rotations to several hospitals.

and ophthalmology; to the University of Ottawa for ophthalmology; to the University of Ottawa and Queen's, Kingston, for psychiatry.

The accreditation standards that the Royal College has developed include the number of beds the hospital is able or prepared to set aside for resident teaching and training; the volume of inpatient and outpatient work done in the specialty; and the standing and reputation of the staff, including, importantly, the heads of department. At first, great reliance was placed on written information returned by the hospital and on the personal knowledge and contacts of members of the Council of the College. Later the facilities of the CCHA were used, including the reports of its survey teams. But eventually the Royal College decided that it must have a survey program of its own, including on-site inspection, and it has been getting more and more involved in this since 1963. The first round of approvals has recently been completed (i.e., all hospitals and institutions offering training in Canada have now been surveyed). It is proposed that this be continued in five-year cycles. The act of accreditation is especially important because the College exercises no direct control over the detailed content or the conduct of the training, nor over the programs of individual trainees. When the trainee applies to the College for permission to sit the examinations, he must persuade the Credentials Committee that his performance has satisfied his training supervisors; but if *they* have not provided him with satisfactory training, it is then too late to do anything about it.

The training requirements for all specialties provide that candidates must have spent a minimum of two years in resident training (or equivalent). In most specialties, the first year is spent in clinical training in either general medicine or general surgery. During this time, they must have been given increasing responsibility under supervision for patient care, and they must have been thoroughly exposed to those aspects of the basic sciences that relate to the specialty. They must have become familiar also with methods of research and the critical analysis of scientific data. It is in these latter respects especially that affiliation with a university is important; and this is why, in general, the College believes that it is the teaching hospitals closely affiliated with the medical schools that are best equipped to conduct full programs of advanced graduate training. Hospitals not in this category may be — and in practice are — approved for the first year or first two years of the program, or for certain aspects of it, but usually only where the College is satisfied that the training obtained will be integrated with a program providing full training in the specialty.⁶ Partly because of this, the medical schools are beginning to get more closely involved in training for the College qualifications, even though their prime purpose at the graduate level is to prepare candidates for higher degrees. In addition it is important that a proper balance be kept between the obligations of the resident to the

⁶Because trainees moving from one hospital with only limited approval to another similarly placed usually cannot obtain graded responsibility for supervised patient care.

hospital and its patients, and the hospital's obligations to the resident to see that he has time to devote to his studies and receives the proper guidance and encouragement.

A hospital applying to establish an advanced graduate training program must meet the following requirements: accreditation by the CCHA; approval by the CMA for junior interne training (general hospitals); high quality and good organization of staff; adequate availability of patients for teaching; adequate arrangements for advising the candidate before he embarks on specialty training and for assessing his progress; proper library facilities; and a high autopsy rate. The general nature and organization of the proposed teaching program also is a major factor. Beyond these basic matters, the various specialties demand further satisfaction appropriate to the specialty; in anaesthesia; there must be at least two certificated anaesthetists on the attending staff; in bacteriology, there must be a minimum of 300 beds in the hospital; in general surgery, the annual number of patients available for surgical teaching purposes must be not less than 300 per junior resident; in ophthalmology, provision must be made for training in the basic sciences related to ophthalmology, and (sic) the members of the attending staff of the department must have no direct or indirect financial interest in the dispensing or sale of glasses and optical equipment; in orthopaedic surgery, there must be an orthopaedic training centre in the hospital consisting of not less than twenty-five teaching ward beds in a designated area of the hospital. (These are examples only.)

Examination Requirements

In order to qualify for entrance to the Royal College examinations the candidate must have a degree from a medical school approved by the College, though (as stated earlier) he need not possess a licence to practise. Normally the College will accept a medical degree that gives the holder full rights to practise medicine in the country in which the degree was granted. At the time of application he must produce evidence of satisfactory moral and ethical standing, and of completion of the prescribed graduate training program. These matters are scrutinized carefully by the Credentials Committee of the College before the candidate is permitted to proceed to the examination. Referees are approached as to his ethical conduct, and the hospital or hospitals in which he trained are asked to assess his progress and rate him in terms of clinical ability, knowledge of the basic sciences, attention to duties, breadth of education and sense of responsibility. A simple three-point scale (Excellent, Satisfactory, Inadequate) is used.

Certification in an approved specialty is taken as evidence that the holder has demonstrated, by training and examination, that he possesses "a satisfactory practical knowledge of his specialty". The standards required for Fellowship are somewhat higher, candidates being required to "display equal or greater

clinical proficiency" and to have "a keener appreciation and a broader understanding of basic science and fundamental principles of medicine and/or surgery". It was stated in evidence⁷ that Fellowship requires "an additional quality, an academic quality, which entails an interest in the furtherance of the specialty by further study, research, and academic pursuit". In fact, two specialties have discontinued the certification and now grant Fellowships only.⁸

How the candidate proceeds is largely a matter of advice, generally from his training supervisors. It is possible to take the Fellowship examination without going through the certification stage (the length of training is exactly the same), and there is a "safety net" in that the examiners are authorized "to grant certification to a candidate who has demonstrated a good practical knowledge of the specialty but failed by a narrow margin to reach Fellowship standards". A candidate may be advised to try immediately for Fellowship; he may be advised to try the Certificate first; or he may be told that he is unlikely ever to reach Fellowship standard. When his application comes to the Credentials Committee of the College, they also may attempt to persuade him to aim either higher or lower, depending on their assessment of his capabilities.

The normal progress towards the examination of the Royal College is as follows. The candidate must do at least a year of general internship in a civilian general hospital⁹ with an interne training approved by the CMA or the Council on Medical Education and Hospitals of the AMA. (He would do this, anyway, to obtain his licence to practise.) Next, he must do four years specialist training, of which at least two years must be spent (in hospitals approved by the College) as a senior interne and/or resident with responsibility for the day-to-day care of patients; and, to this end, "a practical bedside test of clinical ability" is made part of the examination. Residency training in American hospitals approved by the Council on Medical Education and Hospitals of the AMA, or in British hospitals approved by the British Royal Colleges, is accepted.

The disposition of the remaining two years of specialist training (after the basic residency training) depends, in large measure, on the specialty desired. It is unnecessary to go into detail here. The regulations vary somewhat from specialty to specialty. In anaesthesia, for example, the candidate must do a further residency year in anaesthesia (since his first residency year is spent either in internal medicine, or in internal medicine combined with general surgery, or

⁷Royal College of Physicians and Surgeons, Evidence to the Committee on the Healing Arts, November 13, 1967.

⁸These are neurosurgery and neurology, and orthopaedic surgery (though we were informed that the reintroduction of the certificate in the latter is under consideration). Cardiovascular surgery and thoracic surgery have never had certification.

⁹Except in the case of those medical schools which have a planned general internship in which the interne is "rotated" through a DVA hospital for not more than four months of twelve.

obstetrics and gynaecology); he then has a choice of a fourth residency year, spent in anaesthesia, or a year as a clinical research fellow, or a year in the full-time study of basic science.¹⁰ In obstetrics and gynaecology, the candidate must do a further residency year in that specialty (since his first year is spent either in general surgery, or in general surgery combined with internal medicine or pathology); he then can choose a fourth residency year, spent in the specialty, or a year as a clinical research fellow, or a year in basic science.¹¹ In the surgical specialties of cardiovascular and thoracic surgery, and neurosurgery, *five* years of specialty training is now demanded beyond the general interne year. The candidate's choice of options will depend in large measure on the career he wishes and is advised to follow. For example, the man who intends to stop at the certificate in anaesthesia (or obstetrics and gynaecology) might be advised to take the final year of his training as a residency, so as to have three years in his specialty and to become as competent as possible in its practice. The man who intends to go for a Fellowship might be better advised to opt for a clinical research fellowship for the year (which might be in a related field¹²) or to spend a year improving his basic science. The intention of the regulations, indeed, is to be as flexible as possible; or, more precisely, to combine a fairly wide choice of options with a core of basic requirements. The fact that candidates do vary quite widely in their abilities, aims and aspirations is an argument for retaining certification, at least in many of the specialties.

Specialty Recognition

It is sometimes suggested that the Royal College is unduly slow in recognizing and establishing new specialties. This may be more appropriately considered in the chapter dealing with medical education; but it is relevant, here, to refer to the formal arrangements. We have already noted that there is a College advisory committee for each of the specialties and that these are composed, in the main, of people drawn from the appropriate specialty association. It would appear that it is from these sources that the initiative is transmitted to the Council of the College. For example, discussions have been under way for several years on the establishment of a specialty qualification for the allergists. Correspondence initiated by the association was referred to the College's Committee on Specialty Development and informal contacts were made. We were informed that a formal meeting has not yet taken place "because they cannot agree on what they want". In many instances, and perhaps in all, new specialties develop out of old ones, so that the existing College specialty committee may have a major voice in the recognition of the autonomy of the offshoot. When a special field has its own

¹⁰There are one or two other options in each case.

¹¹Again, there are one or two other options.

¹²For example, in pharmacology if he were training as an anaesthetist.

body of knowledge and its own established literature and when there is a sufficient number of people working in that area to demand separate recognition, then the College may be persuaded to grant it. Indeed, when such a stage is reached, the College will usually grant it, provided the specialists themselves can decide upon the kind of training that is needed to produce competent specialists in that area in future.

Unlike the United States, where there are separate boards for each specialty, the Council of the Royal College is a multi-specialty body, and this would seem to have certain substantial advantages. It helps to secure a degree of uniformity in the basic training requirements of all specialties, and it provides a mixed tribunal of physicians and surgeons of various kinds before which the claimants for a new specialty must argue their case. These considerations apply not only to the delimitation of training requirements, but also to the content and conduct of the examinations themselves. The College argues, on the whole convincingly, that its Council is not in the pocket of the specialty associations in these matters, and that it is right that it should not be.

Residency

Certification as a specialist or the granting of the Fellowship of the Royal College is the end of a complex process which begins when the doctor is admitted to a residency in a hospital department appropriate to the specialty he wishes to pursue. The hospital or hospitals to which he is admitted during the course of his postgraduate training are important to him, not only from the immediate point of view of the quality of the training he will receive, but also from that of his future practice — for it is at this stage that he will gain a certain reputation with his superiors and make professional contacts that will be useful, and perhaps even crucial, to him in later life. The most prestigious of these hospitals are, of course, the major university-affiliated teaching hospitals; the least prestigious, the minor affiliated and non-affiliated hospitals. The prestige of the department will depend in large measure on its head. Who gets what residency posts is then a matter of great concern to the general body of young doctors aspiring to residency training.

Distribution of Residents

The distribution of residents by status of the hospital in Canada as a whole in April 1965 is shown in Tables 7, 8 and 9. It is apparently more difficult for the non-Canadian graduate to obtain a post in one of the more prestigious hospitals. Also it is interesting to compare the situation in Canada and the United States. Table 7 indicates that less than 7 per cent of all residents in Canada were training in non-university-affiliated hospitals in 1965; in the United States, however, the figure was nearly 50 per cent.

TABLE 7

**Percentage of Canadian and Non-Canadian Graduates in Residency Training
in Approved Canadian Hospitals by University Affiliation Status
of Hospital, April 1965**

Affiliation status of hospital	Canadian graduates %	Non-Canadian graduates %	All Residents %
Major teaching ¹	70.1	59.5	65.4
Major affiliated ²	18.9	20.7	19.7
Minor affiliated ³	6.5	10.4	8.2
Non-affiliated ⁴	4.5	9.4	6.6
Unable to evaluate			0.1

¹Major teaching: A major university teaching hospital is one which carries a major responsibility for undergraduate clinical teaching for the university medical school and at the same time conducts extensive programs of graduate training in the clinical specialties.

Note: Included in this category are specialty hospitals such as children's and psychiatric hospitals where these are the main teaching centres, both undergraduate and graduate, in the specialty.

²Major affiliated: An affiliated university hospital which is usually, but not always, used for undergraduate training, and in which graduate training is carried on as an integrated part of a graduate training program directed and supervised by a university department or a major teaching hospital.

³Minor affiliated: An affiliated university hospital which is used for undergraduate teaching and which has limited approval for graduate training which is carried out independently of any fully approved university or teaching hospital program.

⁴Non-affiliated: A non-university hospital.

SOURCE: *Canadian Medical Association Journal*, Vol. 94, April 9, 1966, p. 780.

TABLE 8

**Percentage of Canadian and Non-Canadian Graduates in Canadian Hospitals
by the Approval Level of the Hospital, April 1965**

Approved level of hospital	Canadian graduates %	Non-Canadian graduates %	All Residents %
Full training	63.8	47.5	56.8
Three years	8.9	8.9	8.9
Two years	9.8	14.1	11.7
One year	16.6	27.7	21.3
Six months	0.6	0.8	0.7
Unable to evaluate	0.3	1.0	0.6

SOURCE: *Canadian Medical Association Journal*, Vol. 94, April 9, 1966, p. 780.

Finally, Table 9 gives a detailed breakdown of residents by country of origin and shows their status as either landed immigrants or foreign trainees. More than half the residents were Canadian citizens. The American residents were pre-

ponderantly trainees, presumably intending to return to the United States after obtaining their specialist qualifications. The British, on the other hand, were preponderantly landed immigrants as were a high proportion (60 per cent) of the Europeans. About 70 per cent of those from Central and South America, the West Indies, India and the Philippines were foreign trainees; but it is not known how many of these were intending to obtain immigrant status if they could.

Further discussion of residency training is reserved for Chapter 13, on medical education.

TABLE 9

Citizenship Status and Country of Origin of Residents in Approved Canadian Hospitals,¹ April 1965

Country of Origin	Canadian citizen		Landed immigrant		Foreign trainee		No Answer		Total
	No.	%	No.	%	No.	%	No.	%	
Canada	1,796	100.0							1,796
U.S.A.			14	27.5	37	72.5			51
U.K., Eire, Australia, New Zealand			132	86.8	20	12.2			152
Central and South America			22	24.4	68	75.6			90
West Indies			35	30.2	81	69.8			116
Africa			14	51.9	13	48.1			27
Asia and Pacific Islands									
India, Pakistan			49	30.2	112	69.2	1	0.6	162
Philippines			46	29.7	109	70.3			155
Other			66	42.3	90	57.7			156
Sub-total			161	34.0	311	65.8	1	0.2	473
Middle East									
Iran			17	27.4	44	71.0	1	1.6	62
Turkey			28	52.8	25	47.2			53
Other			39	40.6	57	59.4			96
Sub-total			84	39.8	126	59.7	1	0.5	211
Europe and U.S.S.R.			129	60.0	86	40.0			215
No answer			2	6.5	2	6.5	27	87.0	31
Total	1,796	56.8	593	18.8	744	23.5	29	0.9	3,162

¹Approved for residency training by the Royal College of Physicians and Surgeons of Canada.

Chapter 10 Discipline and Control of Professional Conduct

*In every house where I come I will enter only
for the good of my patients, keeping myself far
from all intentional ill-doing and all seduction*

—Hippocrates' Oath

"Probably the most distasteful aspect of any organized program involving the rendering of services by professional persons," says one commentator, "is the internal disciplining of the practitioners."¹ He continues:

This is a simple fact of professionalism, but it has a profound effect
It makes supervision of the quality of the services rendered . . . very
difficult to achieve. The very character of a profession militates against
discipline or regulation of its members.

There are three aspects to this problem. The first concerns the impact of disciplinary controls on the practitioner himself. Are they adequate? Are they fair? Are they administered with justice? And who is to decide? Is it to be left to the profession itself? Or should there be some kind of external surveillance? The second aspect concerns the impact on the public. It is claimed that the preservation of the reputation of the profession and the protection of the public are complementary. But is this always so? The third issue is that of quality control: a related, but essentially distinct matter. Many professions attempt to secure competence and a high quality of service by relying almost exclusively on disciplinary procedures. That is to say, it is assumed that a high quality of service can be secured by the purely negative means of disciplining errant practitioners for "incompetence". Is this good enough?

In this chapter we shall examine disciplinary procedures adopted in the Ontario medical profession and the wider general issue of its professional ethics. The question of quality control arises at various points, but we shall leave a more extended discussion of this until Chapter 11.

Formal and Informal Controls

The law prescribes many things the doctor may and may not do; and (as usual) ignorance of the law is no excuse. He must use great care in prescribing narcotic drugs. He must report all still-births. He must notify the coroner of deaths oc-

¹W. J. Curran, "Legal Regulation and Quality Control of Medical Practice under the British National Health Service", *New England Journal of Medicine*, Vol. 274, No. 10, p. 547 f.

curing in suspicious circumstances. He may not take a corpse out of Ontario for anatomical dissection. Nor may he receive money for "procuring a child for adoption". He is not entitled to compensation for his services as an expert witness in a court case,² and he cannot refuse to testify on the ground that the usual fee for an expert opinion is not forthcoming. In spite of the ancient rule about the confidentiality of what passes between a doctor and his patient, he cannot refuse to disclose information in a court of law if the judge directs him to do so.³ There are things he cannot do without the patient's consent, such as drawing blood; and there are others he sometimes would be wiser not to do, because of the uncertain state of the law, even with his consent (such as sterilization).

But behind the law stands the collective conscience of the profession, and in Ontario the College of Physicians and Surgeons is its keeper. With its "case law" derived from the disciplinary cases that have come before it in the past, and ethical guidance promulgated in its Reports and the "Warning Notice" it sends every year to all registered practitioners in the province, the College represents the major formal control of professional conduct.

A third control applies only to those doctors who have entrée to the hospital. In return for this privilege, the doctor must promise to behave within the hospital in accordance with certain standards, and to carry out prescribed procedures. If he fails, he may have his privileges restricted or even withdrawn.

These — the law itself, the rules of the College enforced by disciplinary powers delegated by the law, and the rules of the hospital promulgated in its medical staff by-laws — are the formal, external controls on the doctor's behaviour. In addition, there are the promptings of his own conscience, the standards he has absorbed during the long course of his "socialization" into the profession, and (last but by no means least) the moral pressures of his colleagues. For the great majority, these are the most important; the disciplinary apparatus is a last resort and (perhaps) the ultimate deterrent.⁴

Discipline by the College

We begin with a brief account of the College's disciplinary apparatus. There are two committees: the Complaints Committee, which gives first consideration to complaints about the behaviour of members of the College; and the Discipline

²Though some doctors, notably surgeons, do a brisk and lucrative business — as expert witnesses in accident cases, for example. There are tricky ethical questions here; for the doctor must not let the size of the insurance company's fee cloud his judgement.

³Except under certain provisions of the Venereal Diseases Acts. In certain cases, the doctors have themselves pressed to have this confidentiality rule restricted: for example, it is now mandatory for a doctor to report to the transport authorities if he thinks his patient's disability renders him "unfit to drive".

⁴Compare: "Ninety-eight per cent of the Registrar's problems are generated by two per cent of the dentists." A former Registrar of the Royal College of Dental Surgeons of Ontario giving evidence before the Committee on the Healing Arts.

Committee, which hears the cases that are thought substantial enough to warrant a hearing.

This machinery is fairly recent. Until 1963 the Discipline Committee was for the most part a fact-finding body, hearing and sifting evidence and submitting written reports to the Council for action. As more cases arose delays occurred, and in 1963 the Discipline Committee was given authority to adjudicate in cases that were thought to warrant a penalty not greater than three months' suspension from the Register. The rest went to Council, on report from the Committee, as before. By a further amendment, in 1966, the Committee was given power to determine all cases; but penalties of twelve months' suspension or more, or erasure from the Register, can be imposed only by the Council itself. Thus, the Discipline Committee is now *de facto* the disciplining body for the profession (though it can be overruled by Council), and the Council is restricted to major sentencing and the hearing of appeals.

The Complaints Committee was established in partial response (there were others, noted below) to certain remarks from the bench in the case of *Glassman v. The College of Physicians and Surgeons of Ontario*. This was a "natural justice" case involving a doctor practising industrial medicine who was reprimanded by the Discipline Committee for professional misconduct: namely, sending a circular advertising his services to a company with whom he had no professional relation.

The Discipline Committee consists of five members of Council appointed annually by Council, which designates one of them as Chairman. The members may be reappointed, and in fact three of them usually are, to ensure continuity. There are no representatives of the public interest. The Complaints Committee consists of a Chairman (the immediate Past President of the College) and two other members of Council appointed annually by Council. None of them may be a member of the Discipline Committee.

How Complaints Arise and Are Handled

Complaints come from many sources: from patients, from members of the public direct or via the press, from other doctors, from dentists and pharmacists, from the police, from insuring agencies, from the courts, from government agencies such as Narcotics Control, and (since it is now mandatory under Section 36 of the Public Hospitals Act for Boards of Trustees to report all disciplinary action taken by the medical staff against a hospital doctor, except in minor matters such as failure to keep records up to date) from public hospitals.

The Registrar makes preliminary inquiries: for example, as to whether the case really comes within the jurisdiction of the College, and as to the good faith of the complainant, and he may interview the doctor at this time. It is understood that nothing the doctor says then will be used against him later. In many instances, the complaint can be settled on the spot. It may be frivolous;

it may be distorted or untrue; it may be possible to handle it informally. The Registrar may simply warn the doctor that persistence in his conduct is likely to lead to trouble. Or he may find that there has been a genuine misunderstanding on the part of the complainant. It appears that there is an informal agreement with the Toronto press that complaints about medical practitioners coming into press offices will be forwarded direct to the College and kept out of the newspapers.

If the Registrar thinks there is a *prima facie* case to answer, he will refer the matter to the Complaints Committee. He must notify the doctor that he has done so, describing the nature of the complaint against him and telling him the date on which the Committee will consider it. The doctor is invited to submit written observations, but he cannot appear at this stage (the Complaints Committee does not hold oral hearings). After investigation by the Complaints Committee the matter may be dropped; though, even if the Committee decides there is no reason to proceed, it may instruct the Registrar to issue a warning or an admonition. On the other hand, it may decide to refer the issue, in whole or in part, to the Discipline Committee.

The proceedings then take a more formal turn, though far short of a court of law (and less formal than, say, the Disciplinary Committee of the U.K. General Medical Council. This Committee meets in a sombre oak-panelled and galleried chamber at the Council's office in London, a chamber which looks, as one commentator has said, like a cross between a law court and a library⁵). The doctor is entitled to attend the hearing (which is held in the offices of the College in Toronto) and to be represented by counsel. Neither may be present, however, when the Committee deliberates its findings; nor may the Committee's Counsel (the Assistant Solicitor to the College) be present at this stage — another result of the *Glassman* case — except when he is needed to advise on a point of law. If that occurs, the doctor's solicitor also is entitled to be called in. The Registrar is supposed to take no part in the proceedings except to report matters of fact. Testimony is taken orally on oath, and although verbatim shorthand notes are made, they are not transcribed unless the defendant specifically asks for them for an appeal (in which case he must pay for them). Hearings are in camera and the complainants have no right to be present, except as witnesses, unless the Chairman so rules. The defendant and counsel have full rights to cross-examine and subpoena witnesses, and the burden of proof is on the College.

The matter is settled by a majority vote on a show of hands, and the Chairman has a casting vote, which (we were informed) it has occasionally been necessary to use. In such cases, the penalty would be scaled down for lack of unanimity. Dissenting members may have their disagreements recorded. It is not required that the Committee give reasons for its decisions, though it may do so. The Committee reports each case to Council, meeting as necessary, usually about three times a

⁵Paul Ferris, *op. cit.*

year and preferably about a month before a Council meeting so that an appeal, if any, can be heard. There is no time limit on the bringing of cases (in one case, that of falsifying a certificate, the act had occurred six years previously).⁶

There is no routine "policing" of the profession: the College relies exclusively on complaints, public reports and the professional "grapevine". It shares with the Royal College of Dental Surgeons of Ontario an inspector (a former member of the RCMP) whose job it is to act as an inquiry agent for particular investigations in cases reported.

From time to time the College receives from the Supervising Coroner (or local coroners) reports of inquests at which there have been suggestions of incompetence or neglect on the part of a member of the College. Where the death occurs in hospital, medical audit procedures also may be put into operation by the hospital medical staff (see below). The College follows up these reports and, where appropriate, the offender may be brought before the Discipline Committee. There are (or may be), in fact, three sets of authorities involved in such cases. There may be a coroner's inquest (and there have been, of late, serious allegations that not enough inquests are being held in cases where medical negligence is suspected); there may be an inquiry into the death within the hospital itself (and a doctor may have his privileges reduced or removed even though the coroner's jury attaches no blame);⁷ and there may be further inquiry by the College as to possible disciplinary proceedings.

Disposal of the Case

When the Discipline Committee finds the defendant guilty of professional misconduct, the action taken depends on the gravity of the offence and any mitigating circumstances. In the gravest cases, the member may be struck off the Register. This is a terrible step for a private tribunal to take, for it can mean the end of a professional career: the man's peers are, in effect, condemning him to professional death. It is true that he may be reinstated later, on proof that he has mended his ways or exorcised his guilt, but the sentence can never be wholly eradicated in the mind of the profession.

Next in order of gravity comes suspension from the Register, which may be for any period of time. Suspension of more than twelve months can be imposed, as we noted above, only by the Council of the College; suspensions of lesser duration may be authorized by the Discipline Committee itself. Notice of

⁶Compare malpractice suits, which must be brought before the courts within one year of the "termination of treatment".

⁷In the Somordolea case an elderly woman died, allegedly as a partial result of a transfusion of too much blood before an operation for a skin-graft. No inquest was held, but later one was called for (by the Attorney-General of Ontario). The jury found no medical negligence, but a doctor was disciplined by the hospital and had his hospital privileges reduced. No action appears to have been taken by the College.

erasure or suspension is sent to every licensing body in Canada, the United States and the United Kingdom; to the Ontario College of Pharmacy, the insuring plans and interested government agencies. The names of all those against whom disciplinary charges have been upheld are revealed. The press usually publishes the details.

Third in order of gravity of sentence come serious reprimand or reprimand, either of which may be (but need not be) directed to be entered on the Register. Fourth comes postponement of sentence (indefinitely or for a specified period) with certain conditions attached. It should be noted that even when the charge is found to be not substantiated, the College may "express its concern" and issue a warning. For example:

Dr. S. was charged with being guilty of infamous, disgraceful or improper conduct⁸ in that he committed adultery with a patient. On the evidence presented the Committee concluded that Dr. S. did not commit adultery as charged and therefore the charge was dismissed. However, certain aspects of the doctor's professional conduct in the case disturbed the Committee and the Chairman was directed to bring these to Dr. S.'s attention.⁹

Where the charge is a grave one, the College exercises its function as humanely as possible, sometimes by making use of the Special Register. In cases involving professional misconduct in one aspect of the doctor's practice, or where there are appropriate mitigating circumstances, it is possible to direct that his name be placed on this Register. For example, where a doctor has himself become addicted to a drug or an anaesthetic but is in other respects a competent doctor, or where he has overprescribed narcotics to patients, he may be placed on the Register with limited practice privileges. In one case, involving a psychiatrist who had had improper relations with a woman patient, entry on the Special Register was ordered, restricting him to practise in a hospital and under supervision. At the time of our inquiries there were said to be about eighteen "discipline" cases on this Register. It was suggested that the Special Register may also prove useful, in appropriate circumstances, where the doctor is the only one in the locality: his practice privileges may be restricted but his patients will not be totally deprived of medical attention. On the other hand, it would appear that the College is adamant in refusing to allow doctors to return to practice before the expiry of sentence of suspension, even though their services may be urgently needed.

Suspension or erasure from the Register sets off a kind of chain reaction: the member would likely lose his membership of the OMA, the CMA and his local medical society; he would be liable to have his Medical Council of Canada

⁸Author's note: This was before the change in the definition of professional misconduct noted below.

⁹Report of the College, January 1, 1964, p. 15.

licence suspended or revoked; and, if he were a member of the Royal College of Physicians and Surgeons of Canada, he might lose his specialist rights too.¹⁰

In cases of erasure, or suspension for a prolonged period, the practitioner may be required to pass examinations or to intern again before being reinstated. In any event, he may not be reinstated immediately with full privileges: he may have to work his way back by first being placed on the Special Register with restricted practice rights (for example, to practise only in an institution under supervision).

When the Registrar has any reason to suspect that a suspended or erased doctor is still practising medicine, the Inspector may be instructed to make inquiries; but there is no regular "follow-up" of discipline cases or continuing surveillance, and in fact there has never been a case of a prosecution for this offence.

It would appear that most practitioners eventually get reinstated — at least partially — if they want to. The length of time this takes depends on the nature of the original offence. For example, if the member performed an abortion for therapeutic, though illegal, reasons, he would be likely to be returned to the Register within a fairly short time; if he performed an abortion strictly for financial gain, he might never be reinstated. Similarly, a member who had a drug or alcohol problem might be reinstated as soon as it could be shown that his condition had improved to the point where he was safe to return to practice.

Appeals

Appeals from a decision of the Discipline Committee or the Council, which must be made within thirty days, go from the Committee to the Council or to a judge of the Supreme Court of Ontario (the choice¹¹ rests with the member), and from the Council to a judge of the Supreme Court. In both cases there is provision for further appeal to the Court of Appeal. Following the *Glassman* case, the Council may on appeal confirm, vary or reverse the decision of the Discipline Committee, or remit the case for a rehearing. All appeals are on the evidence originally adduced: no new evidence is admissible. Applications for reinstatement are treated in the same manner as the original complaint, and the same rights of appeal apply also.

¹⁰We were informed that this has happened on several occasions. The Ontario College can, of course, prohibit a practitioner from using his specialist qualification *within the province* (by removing him from its specialist list), but it cannot itself revoke the Fellowship or Certification of the Royal College. The Royal College has its own Ethics Committee, but it normally acts only on reports from the provincial licensing authorities and has no power to compel erring Fellows or Certificants to appear before it to answer charges of unethical behaviour.

¹¹The College intends to have this provision amended to give a right of appeal to a judge of the Supreme Court only. This means that the only function remaining to the Council of the College will be that of settling penalties in the more serious cases.

A disciplinary proceeding may be quite expensive for the doctor. He must bear his own legal expenses and may have to pay costs (in practice this is ordered in virtually all instances where the charge is upheld).

There is no evidence of political interference in the disciplinary function of the College, and it is certain that the profession would take a serious view of any attempt on the part of a doctor to bring such influence to bear. There was a case in the 1930's when the then Premier of Ontario threatened to have a private act passed to reinstate a physician who had been struck off the Register, but the threat never materialized.

Unethical Conduct

Until 1960 the College had to determine whether the offender was guilty of "infamous or disgraceful conduct in a professional respect". The formidable phrase, "infamous conduct", redolent of Victorian moral rectitude, originated in the (British) Medical Act of 1858. It has been retained ever since, though with increasing misgiving. One eminent British judge has held that it implies "no more than serious misconduct judged according to the rules, written or unwritten, governing the profession". In other words (those of the General Medical Council in its most recent brochure on the subject), it means "a serious breach of medical ethics".

"Infamous" still appears in the Medical Act of several Canadian provinces (in those of Prince Edward Island, New Brunswick, Alberta and British Columbia, for example), though almost always in conjunction with some relatively less opprobrious term such as "improper" or "disgraceful". It is not really very surprising that, until the wording of the Ontario Medical Act was changed, only offences of the most serious nature were brought. This is reflected, in part, in the following table, showing cases disposed of by the College over a ten-year period.

1956	—	3
1957	—	0
1958	—	1
1959	—	0
1960	—	1
1961	—	6
1962	—	6
1963	—	10
1964	—	14
1965	—	13
1966	—	15

It was in 1960 that the wording became "infamous, disgraceful or improper". Later the whole phrase was replaced by "misconduct in a professional respect or conduct unbecoming a medical practitioner". To this was added, in 1965, the words "or incompetence".

Establishing "incompetence" is a matter of some difficulty. In the broadest sense of the term, it is related to quality of service, and there are as yet only rather rudimentary means of assessing this. One issue, mental illness, is dealt with in the Medical Act. Section 35 of the Act was added in 1960 at the request of the College. This calls for the reporting to the College of all admissions of a doctor to a mental institution upon certification, and of all admissions of a doctor who has not been certified on the sixty-first day of his treatment. The section has proved to be unsatisfactory. In non-certifiable cases, the patient is frequently discharged on the sixtieth day (and then, perhaps, readmitted) in order to avoid having his name removed from the Register, as the law requires. The College has frankly admitted that the section is inadequate and impractical. As it rightly points out, there is no more reason to notify hospitalization for mental illness than for any other disabling condition; and there is the problem of what to do about the doctor who is not hospitalized but takes his treatment from a private practice psychiatrist. At the same time, the College expresses a genuine concern to devise some means "by which a mentally ill practitioner (can) be removed from practice before . . . harm befalls the patient". The College is continuing to explore this problem in consultation with the various mental health agencies.

Still construing the term "incompetence" narrowly, there is the question of age: the usual presumption being that competence diminishes with advancing years. The problem here is that there is no fixed age at which it can fairly be said that any doctor will be incompetent to practise (i.e., a compulsory retiring age is not the answer; though, as we saw in Chapter 5, many hospitals do have such a provision for their active staff).

There are two circumstances in which a finding of professional misconduct *must* be returned: first, when the member has been convicted in Canada of an indictable offence, or, elsewhere, of an offence that, if committed in Canada, would be an indictable offence; and second, when his rights and privileges under the Narcotic Control and Food and Drugs Acts have been withdrawn. In such cases, it only remains for the College to assess penalties. The College keeps in close touch with the Narcotic Control of the Department of National Health and Welfare. The Division usually warns practitioners when their prescribing (of narcotics or other controlled drugs) is thought to be wrong or excessive; if they fail to heed the warning, they are reported to the College.¹² When this occurs, the Registrar invariably interviews the doctor, and only when this too fails will the case go to the Complaints Committee. The power of the Narcotics Division to withdraw privileges, which would lead to an automatic finding of unprofessional conduct, is used only after the doctor has been given an opportunity to mend his ways. Correction and rehabilitation of the offender, rather than punishment, is the stated aim.

¹²The Division is, however, seriously understaffed and there have been suggestions that the degree of control is inadequate.

There is one circumstance in which a finding of professional misconduct *must* be followed by erasure from the Register: when the member has been convicted of a criminal offence "committed in connection with the practice of his profession". The question as to who is to determine such a connection is left in doubt, but in practice the section has been invoked only when the connection is plain — namely, in cases of conviction of criminal abortion.

Standards of the Profession

These are instances where professional misconduct is statutorily defined. For the rest, as to what constitutes "misconduct in a professional respect", or "conduct unbecoming a medical practitioner", the profession itself is the judge. The starting point is the Code of Ethics of the CMA, which has been adopted by both the OMA and the College. The OMA Ethics Committee meets infrequently (usually once a year) and its main function seems to be to assist the OMA in making representations to the College and to the CMA on specific ethical questions as they arise (relations with chiropractors and dispensing by physicians are typical items on the agenda).¹³ The College Ethics Committee has the more formidable task though it, too, meets infrequently.

It was argued that the edicts of the College form the major guide to professional conduct. This is true; but one must add that there is uncertainty where the College is silent and sometimes, even, where it is not. The Rubric accompanying the College's annual Warning Notice reads in part:

This notice is issued for the information of practitioners concerning the disciplinary jurisdiction of the College and the nature of the offences that have led or may lead (sic) to erasure or suspension from the Register. *The offences specified do not form an exhaustive list* (Emphasis added.)

At the same time, the College states that the CMA Code "is only a guide and *does not bind or limit the Council* in determining whether the conduct is unprofessional". There is, therefore, a sizable, though indeterminate, area in which there are no precisely specified rules. The prudent practitioner may well decide to ask the OMA or the College for advice: but he may not necessarily get an unambiguous answer.

The Code of the CMA is, then, a basic document. Yet, as it now stands (and it is at present under review), it is a curious mixture of worthy but highly general admonitions that could hardly be enforced (such as that the first consideration of the physician is the welfare of the sick, and that he must be "ever anxious" to keep abreast of advances in medicine); more precise recommendations (for example,

¹³The Committee is also much concerned with the "public relations" aspect of professional ethics: with "the good name of the profession". See, for example, its stand on "confidentiality" at a time when the patient's medical record becomes more and more a public document.

about seeking second opinions in cases of abortion and poisoning, and about the inadvisability of doctors treating themselves or their families when another doctor is available); and highly specific directives (such as those forbidding fee-splitting, self-advertising and the "knocking" of other doctors, and canvassing for a place on the medical staff of a hospital).

Some parts of the Code would seem not to relate to ethical matters at all (at least in the strict sense). For example, there is a provision that "a physician should (sic) associate himself with local, provincial and Canadian medical organizations to promote both his own and the general advancement". If such a "rule" were enforceable (which, of course, it is not), it would raise serious questions in the mind of any public authority that was concerned with the freedom of the individual. Slightly more marginal, perhaps, is the provision that the doctor should not publicly express opinions that are not "the generally accepted opinions of the medical profession".

There are similar oddities in the International Code of Medical Ethics of the World Medical Association, a document that bears the unmistakable stamp of influence of the American Medical Association. This is reprinted in the CMA Code, though its exact status there is not made clear. This deems "unethical" (among other things) "taking part in any plan of medical care in which the doctor does not have professional independence". This may be a proper political sentiment for the doctors of the world to assert, but it is surely too vague to rank as a rule of ethical behaviour.

There are, then, a number of features of the Code of Ethics that may be thought to be matters of public concern. It is a mixture of vagueness and specificity, and it is often far from clear what is being demanded of the doctor and what protection is being offered to the patient. It is a mixture, too, of intentions. Some of its provisions are designed to protect the patient; others are aimed at keeping the doctor within the law; and others again are attempts to secure professional solidarity, restriction of competition and compliance with majority opinion. A few are not ethical matters at all. It is by no means clear that all operate in the public interest. And it is possible to argue that some issues (of which overcharging and bad treatment are the most obvious) would be better handled by methods other than disciplinary ones. The Code undoubtedly reflects the strong concern for self-protection that is inherent in the disciplinary apparatus as a whole. This concern is illustrated, for example, by the practice (only recently abandoned) of referring all cases of alleged fraud against insuring agencies and prepaid medical plans to the College and not to the courts, thus evading the publicity of legal proceedings.

The CMA is at present engaged in what was described to us as a "complete rewriting of the Code of Medical Ethics". This was to have been ready for the annual meeting in June 1968, but we understand that it is now likely to be delayed for another year.

In the latest edition of the College's Warning Notice (for 1967) the following appear, unequivocally, as disciplinary offences: adultery with a patient (there is no mention anywhere of homosexuality); advertising and canvassing; making untrue, misleading or "otherwise improper" statements in certificates, reports or other documents; submitting false accounts; associating with unqualified or unregistered persons "whereby such persons are able to practise medicine"; attending patients under the influence of drugs or alcohol; abuse of drug-prescribing; gross negligence in the treatment of patients; fee-splitting. An appendix at the end of this chapter analyzes the cases that have actually been the subject of disciplinary proceedings in recent years.

Apart from principles that have been or may be derived from these, there are what the College calls "Regulations" (though they appear to have no kind of direct statutory authority). These, we are told, "may form the basis of disciplinary action". Some of them refer to issues of considerable controversy in the profession, including some that have figured on the agenda of meetings of the Joint Committee of the OMA and the College. They include "regulations" about dispensing by doctors, and referral of patients to chiropractors and podiatrists. Others are enunciated, it seems — at least in part — in the course of disputes with other medical interests and are thus, in a sense, instruments of ideological (or, as the OMA would prefer, "philosophical") warfare: they are principles of a sort, but hardly ethical principles *per se*. This is particularly true of the "principles governing proper charges", where there is a long-standing difference of opinion, only now temporarily laid to rest, between the College and the OMA.

Sometimes the dispute is with members of other health professions. The College points out in its Warning Notice that it is an offence under the Pharmacy Act for anyone but a licensed pharmacist to dispense on the doctor's behalf. The doctor can, of course, do his own dispensing, but he cannot allow his receptionist, nurse or other aide to do it for him. If he does, it is not he who is legally liable, however, but the receptionist or nurse. The College of Pharmacy does not like this and is highly critical of the College of Physicians and Surgeons for an alleged failure to take effective action on what it admits is, indeed, a disciplinary offence.

There is a further source of controversy in this matter of dispensing. It is argued, with some justice, that to forbid a doctor to dispense would inconvenience patients in the remoter parts of the province. There is also the fact (usually unstated) that the high cost of drugs leads doctors in some areas to buy in bulk and do their own dispensing for patients at a lower price than the patient would have to pay at a retail pharmacy. Going one stage further, there have been cases of doctors buying in bulk and selling at a profit to other doctors. This is clearly unethical (since doctors are not permitted to "engage in business" related to their profession¹⁴), but a difficult problem arises in deciding what margin of profit it is ethical for a doctor to take from his patient.

¹⁴There is apparently nothing to prevent them from engaging in other forms of business activity, however (e.g., speculation in real estate, owning motels, and so on).

The rules about advertising raise exceptionally tricky issues. The doctor must not "distribute cards or notices advertising himself to lay people" (some members of the College were reprimanded a few years ago — see Appendix V — for publishing a message of Christmas greetings in the local press). He is allowed to advertise the fact that he is establishing a practice in the town, but this must not exceed three insertions in a newspaper. He may list his name in the Yellow Pages, but not in bold type, and he must not show his office hours there.

Advertising is quite often inseparable from the "communication of opinions on medical subjects to the laity", particularly when these are expressed in the press and on radio and television. All such opinions are supposed to be presented as from some recognized source, such as a medical society or association, and not from the individual physician as such. But the rule is frequently broken, and it is difficult to see how it could be otherwise: witness the intense public interest in, and numerous statements by, individual physicians concerning the Dr. Gordon Murray spinal-cord case and the heart-transplant cases. It may be argued that these statements were not, for the most part, made in the course of "programs", but at conferences and the like at which press and radio happened to be admitted. But the dividing line is thin. We were told that it is usual for a doctor to consult the CMA and/or the OMA before making a radio or television appearance, and that the media editors, producers and others keep in touch with CMA and OMA headquarters. It may be cynically suggested that a doctor is more likely to "get away with it" when he is known to be presenting a view satisfactory to the majority than when he appears as a renegade or "oddball".

The doctor is supposed to take care that the "announcer" (sic) makes "no laudatory comments and no unnecessary display of medical qualifications and appointments". But, while not all are blessed with the flair for drama and panache of a Dr. Christian Barnard, any doctor who has just done something newsworthy will find it hard to avoid "undue publicity".

The most famous recent advertising case, perhaps, was that of a British doctor, Mr. Leslie Gardiner, an ear, nose and throat surgeon who turned to plastic surgery. He was struck off the Register (and his appeal to the Judicial Committee of the Privy Council failed) for writing a book called *Faces, Figures and Feelings* and several articles for newspapers and women's magazines. The case was given enormous publicity and the General Medical Council was made to look slightly ridiculous. As Mr. Gardiner said: "If I had been writing about varicose veins or duodenal ulcer no one would have bothered. But I was writing about the hottest subject in the profession." This might be disputed, at least technically, for what he was held to have done wrong was not to have written about cosmetic surgery as such (which some doctors consider dubious practice anyway) but to have done so in such a manner as to "advertise for the purpose of promoting (his) own professional advantage". Since a man may practise as a doctor in Britain even though he is not on the Medical Register (though he cannot take part in the

National Health Service), Mr. Gardiner's livelihood (a rather profitable one) was not adversely affected by the decision.

An even more troublesome issue from a disciplinary standpoint is that of strike action. This is not referred to in the College's Warning Notice; but the College's representatives appearing before the Committee on the Healing Arts agreed that if doctors "withheld their services" in certain circumstances, such as the furtherance of a dispute with the government over medicare, the College would "discharge its responsibility (sic)" and discipline the doctors concerned, even though it was recognized that discipline on a large scale would be extremely difficult.¹⁵ Of course, this pronouncement received wide publicity; and, although it is hard to take its intention seriously, it is significant, both as an indication of the high moral line taken by the College and as evidence of a wide divergence of opinion between the College and the OMA on certain matters of pressing concern to the profession.

Discipline by Local Societies

The disciplinary function of the College is reinforced, at least in principle, by two other sets of institutions: the local medical societies and the organized medical staffs of the hospitals (in some instances, as we saw in Chapter 5, these are formally the same).

The role of the local medical society in this respect is ambiguous. Complaints certainly come to the OMA from time to time, particularly about maverick doctors who speak "frequently and indiscreetly" (as one report puts it) on public issues in the health field; and the society making the complaint is usually seeking guidance as to how far it can or should go in restraining the troublemaker.

The College of Physicians and Surgeons favours the handling of "minor ethical problems" at the local level, and the OMA urges all its branch societies to establish ethics committees. The procedure currently suggested is that when a breach of ethics is reported, it should be investigated by the local ethics committee first. A report should then be sent by the committee to the executive of the local society with a recommendation indicating whether the matter can be resolved locally or whether it should be referred to the College. Our inquiries (see Chapter 3) indicate that local societies are generally reluctant to formalize their disciplinary procedures and prefer to rely on moral suasion and social pressure. Among the societies from whom we made inquiry, only the Toronto Academy had a formal procedure for disciplining its members, and this was not much used. The Hamilton Academy left all cases to the OMA and the College. The Hastings and Prince Edward Society said it had never been involved in a case, even though doctors within its jurisdiction had been disciplined by the College. (The society

¹⁵One representative qualified this by suggesting that if the doctors who withdrew their services made proper arrangements for the care of their patients before doing so, the question of discipline might not arise.

drops from membership any doctor whose licence is suspended by the College, since a licence to practise medicine in Ontario is a condition of membership.) The ethics committee of the Leeds and Grenville society had met for this purpose only once in the previous five years. This was a case of unprofessional conduct involving an alcoholic who was also disciplined by the local hospital.

The local society has no sanction at its disposal beyond expulsion from the society, though this may have considerable symbolic importance. The real sanction lies in its links with the local hospital or hospitals, and some hospitals make "good standing with the local medical society" a condition of acceptance on the medical staff.

Discipline in the Hospital

The regulation requiring hospital trustees to report disciplinary cases to the College has bolstered the power of the hospital medical staff;¹⁶ on the other hand, it has tended to make the hospital more reluctant to discipline a member formally lest this result in a more severe "sentence" at the College level. In one case a specialist had his surgical privileges suspended by the hospital "because of an unusually high incidence of complications in a certain surgical procedure". The case went to the College Discipline Committee, which heard testimony from the chief of staff, the head and former head of the department, two consultants and an emeritus professor in the specialty. The doctor also gave evidence on his post-graduate training and his reasons for the complications. The College ordered that he should have no major operative privileges until he had undergone a further period of specialist training.

Part of the difficulty, it seems, is that there is no clear distinction between "quality control" aimed at securing the best possible standards of patient care in the hospital, and disciplining for incompetence. Indeed, it can be argued that the atmosphere of sanctions and penalties that surrounds so much of the discussion of hospital privileges is positively inimical to the development of professional excellence. Many, if not most, of the relevant rules contained in Regulation 523 and in hospital medical staff by-laws relate to the securing of proper medical administration in the hospital: the establishment of proper lines of communication and levels of authority; the keeping of essential records; consultations and "second opinion" in appropriate cases, and so on. These matters are not unrelated to the question of quality of service, but they are essentially secondary.

The power of the medical staff to discipline relates not merely to breaches of the hospital rules or Regulation 523, but also to judgements about competence,

¹⁶In effect the regulation means that disciplinary offences are "registered" with the College (whether or not the College itself takes any further action); and it is common for a hospital, on receiving an application for admission to the medical staff, to inquire of the College whether there is "anything known" against the doctor concerned.

a much wider matter.¹⁷ It goes without saying that the larger and more complex the hospital, the greater the difficulty of securing effective quality control with the present instruments available.¹⁸ The problem is partly one of securing adequate record-processing and information retrieval, and partly (though this is not unrelated to the former) one of sheer pressure of work. It has been suggested,¹⁹ for example, that the rather tragic dispute over Dr. Gordon Murray's spinal surgery might not have occurred had the medical audit at Toronto General Hospital been working better, and that in many hospitals medical audit does not work well because the doctors concerned are too busy.

The advent of electronic data-processing such as is now provided, for example, by the Hospital Medical Records Institute (see Chapter 11) is a great step forward. Not only does this speed the preparation of essential documentation and aid in checking and cross-tabulating, but it also makes possible the production of a mass of information that would not otherwise become available. In the process, it should greatly relieve the strain on medical committees and enable them to do more effectively the job for which they were intended: the making of decisions. This needs to be kept in perspective, however. EDP makes even more necessary the keeping of full and accurate records, and it cannot alter the fact that, in the last resort, the assessment of medical competence is a matter of professional judgement. Moreover, as was said in Chapter 2, all professionals hold tenaciously to the view that only the colleague-group (in this case other doctors) who are subject to the same work risks have the right to make this judgement and decide in a given case if an error has been made.²⁰

¹⁷It may also be invoked for personal misconduct. For example, at Toronto East General a resident was disciplined for being late for some operations and for making derogatory remarks about a guest speaker at a hospital party. He was dismissed and he was reported to the College.

¹⁸It does not follow that things are necessarily any better in a small hospital. We were informed that one of the reasons for the establishment of the OMA's Committee on "Operating Room Deaths" (or Committee on Mortality Associated with Operative Procedures, to give it its proper title) was that audit in many smaller hospitals left much to be desired.

¹⁹By Robert Ferguson, the Administrator of Humber Memorial Hospital. Reported in the *Toronto Star*, December 5, 1967. Mr. Ferguson is reported as having said that hospitals are falling down on checking medical work because it takes too much time and too much "donkey work".

²⁰"He who is without blame, let him cast the first stone I am always terrified every time I do an operation I have made mistakes . . . the only thing is the coroner never learnt about them (laughter)" — Dr. Gordon Murray in a recent hospital death case.

See "M.D. sewed wrong section of colon, Jury told", *Globe and Mail*, January 20, 1967. In this case a resident surgeon at St. Michael's Hospital sewed up the wrong end of a seventy-four year-old man's colon in an operation intended to short-circuit an incurable cancer of the rectum in order, it was said, to make what remained of his life "more comfortable". In the light of this humane intention, Dr. Murray's reported remark to the coroner's jury that "the only thing wrong was in the selection of the wrong end of the colon" reads a little oddly. Dr. Murray maintained that the process of finding the right end was like "trying to see a handkerchief at the bottom of a washing machine when the machine is on".

The point was made earlier that a disciplinary atmosphere may well be inimical to improvements in "quality control". It is interesting, in this connection, to note a recent statement that resistance to the acceptance of EDP has come from doctors who fear that the more effective the system becomes, the greater the likelihood that medical records will be used against them. If the disciplinary aspect can be set aside, this resistance might be overcome. For example, at the Port Arthur hospitals, which have adopted HMRI:

When there is need for correction, the individual doctor is approached privately, with nothing on the record and no fuss Doctors will usually realize that they are out of step and strive for improvement.²¹

When disciplinary action *is* invoked by a hospital medical staff and/or (in the larger hospital) by a head of department, what rights does the doctor have? Our inquiries suggest that although the medical staff by-laws follow a fairly consistent pattern (as one might expect, given the existence of OHA/OMA prototypes and CCHA accreditation procedures), there is some variation in the way in which disciplinary cases are actually handled. We understand that the College is at present conducting a campaign to "educate" hospital medical staffs: on the one hand, to press them to take their responsibilities more seriously; but on the other, to prevent injustices. The College regards it as one of its functions to be satisfied that any doctor who is disciplined receives fair treatment. In the case mentioned above (the case of the specialist who lost his surgical privileges), it reprimanded the hospital's chief of staff and Medical Advisory Committee for not following the rules of natural justice. In the case of a gross abuse of the doctor's rights, the College has stated, the members of the Medical Advisory Committee might even find themselves on disciplinary charges.

The general impression we formed was that, whatever the formal arrangements may be (and they do differ quite markedly from hospital to hospital — at least in detail), an appeal to the Board of Trustees is seldom resorted to. This is because the Board invariably accepts the views of the Medical Advisory Committee and the doctor believes an appeal would be futile. An appeal from a department head goes to the MAC; but a reversal of his decision is improbable, since it would be tantamount to a vote of no confidence and would almost certainly lead to his resignation. It should be noted that in teaching hospitals, where there are joint appointments, it may be necessary also to secure the views of the Joint Hospital-University Relations Committee before final action is taken.

²¹"HMRI Aids Utilization of Services, Evaluation of Care at Port Arthur", *Hospital Administration in Canada*, May 1967.

Appendix V

Disciplinary Cases heard by the College of Physicians and Surgeons of Ontario, 1962 to 1967

1. Drs. B., F. and O. (case referred to in the text) were charged with having "authorized or caused the publication in the Christmas edition of a newspaper of an announcement of a nature such as to obtain publicity for themselves as medical practitioners". Drs. B. and F. were reprimanded, but Council considered that the case against Dr. O. had not been made.
2. Dr. A. Council in 1961 had found Dr. A. guilty of infamous and disgraceful conduct in a professional respect but, in the interests of his wife and children as well as his own, had postponed sentence. Dr. A. was requested to furnish referees who could testify as to his conduct. Some of these reports were unsatisfactory, and Dr. A. was told that he "should seek professional help and guidance forthwith" and report back. This he failed to do. Severely reprimanded.
3. Dr. S. was charged with having sought to acquire a patient for himself, a person unknown to him, and to have made recommendations as to his medical care without reference to his attending physician, and statements derogatory to the professional ability of the attending physician such as to undermine the patient's confidence in him. Guilty. Penalty postponed.
4. Dr. Engelberth Konseck. Charged with criminal abortion; failed to appear to answer charges (broke bail). Erased from the Register.
5. Dr. Walter Dirnberger. Application for restoration to the Register refused but placed on Special Register with restriction that he engage in salaried practice only, report annually to the Registrar as to his mental health and good conduct. Not to be considered for full registration before 1967.
6. Dr. L. Fraudulent claim against PSI. Not proved. Charge dismissed.
7. Dr. Ahmed Kolin. Accused of having "charged an exorbitant and unconscionable fee", namely the sum of twenty dollars for a death certificate. Suspended for one month. Costs of \$200 (sic).
8. Dr. S. (3 above). Considered again. Reprimanded.

9. Dr. James Borden Arthurs. (Case 2 above, name now disclosed.) After further consideration, erased from the Register.
10. Dr. W. Told that several statements in his printed "Instructions to Patients" were offensive and must be deleted.
11. Dr. K. Failed to show due regard for patients in subjecting them to surgical procedures which were unnecessary and the performance of which could not reasonably be attributed to errors of judgement. Charges not proved, but Dr. K. told of the Council's "concern".
12. Dr. C. Another "incompetence" case. Not guilty.
13. Dr. S. Adultery with a patient. Dismissed, but Council expressed "concern" (see body of text above for details).
14. Dr. D. Driving under the influence of drink. Warned.
15. Dr. Robert Kingsley Graham. Charged: with being guilty of infamous, disgraceful or improper conduct in that he had: 1) attempted to deceive a professional colleague as to the necessity for and/or the result obtained by a surgical procedure upon a patient; 2) entered on a hospital operative record a post-operative diagnosis that he knew to be untrue; 3) exhibited a reckless disregard for the interests of a patient by persisting in his decision to subject her to a hazardous surgical procedure notwithstanding the opinions of colleagues and clinical evidence that such procedure was not called for. The Committee found Dr. Graham guilty of improper conduct in all charges and reprimanded him.
16. Dr. John LaCroix. Improper association with a married woman with whom "he stood in a professional relationship at all material times". Guilty, but "in view of the unusual circumstances", severely reprimanded.
17. Dr. K. D. Johnston. Narcotic privileges had been withdrawn. Guilty. Penalty postponed.
18. Dr. Franz Joseph Woss. Charged with criminal abortion. Failed to appear to answer charge. Bench warrant issued. Failed to answer. Guilty of infamous conduct. Struck off Register.
19. Dr. Charles Edward Baker. Grossly excessive claims against the Medical Welfare Plan. Severely reprimanded.
20. Dr. Denis Docherty. A narcotic drugs case. Placed on Special Register. Not to prescribe narcotic drugs while on probation.
21. Dr. Ira O'Neill. The same — but also "not to charge or accept professional fees".
22. Dr. Strul Strulovici (see also case 60 below). Fraud against PSI and Medical Welfare Plan. Suspended from the Register for three months.

23. Dr. L. V. Roy. Grossly excessive fee. Suspended for three months. Later charged with continuing a course of treatment on a patient when he knew or ought to have known that this was likely to endanger her life; becoming involved "in an improper arrangement with a food outlet in Toronto as a result of which rebates on purchases made by his patient were allowed and received by him"; and knowingly misleading the same patient by promising that he could cure her of cancer. Erased from the Register.
24. Dr. Robert Kingsley Graham (see 15 above). Found guilty upon a number of charges involving hazardous surgical procedures, falsifying hospital records and performing unnecessary operations. Erased from Register.
25. Dr. T. N. Bacon. Fraud against PSI. Suspended for two months.
26. Dr. Ladislav J. Gondor. Fraud against PSI. Suspended for three months.
27. Dr. D. Treating a patient while under the influence of alcohol. Not proved. Charged dismissed.
28. Dr. Thomas Joseph Glover. Using a serum on two patients for cancer. Placed on Special Register "with full practice privileges provided that he cannot employ serum in the treatment of any cancer patient".
29. Dr. Kenneth Alfred Brown. Two charges: of failing to provide adequate post-operative treatment on a patient in Toronto East General Hospital, and failing to properly conduct, perform and complete an operation on another patient in the same hospital. First charge: not guilty; second charge: guilty. Suspended from the Register "until such time as he satisfie(d) the Executive Committee that he (was) in satisfactory general health so as to resume medical practice".
30. Dr. Ellis Shenken. Fraud against PSI. The Discipline Committee "gave full weight to the many mitigating circumstances". Severely reprimanded and directed to make restitution to PSI.
31. Dr. Andrew Ali Hosein. Fraud against PSI. Suspended from Register for three months.
32. Dr. Ennio Melillo. The same.
33. Dr. ———. A charge of fraud against AMS. Argued that this was an isolated instance. In view of doctor's explanation, dismissed.
34. Dr. Luis Carreno-Segura. Flagrant and reckless disregard for his patients by failing to keep proper hospital records. Penalty suspended for one year dependent on good professional conduct.
35. Dr. Luis G. Sarabia. The same.
36. Dr. George Edward Young. The same.

37. Dr. Imre Fejer. Deliberately deceiving the relatives of a patient as to the seriousness of his condition and endeavouring to obtain a substantial sum of money in payment of services that he knew were not required. Suspended for three months.
38. Dr. Alistair E. MacIntosh. Improper relationship with a married woman to whom he stood in a professional relationship at all material times. Suspended for three months.
39. Dr. ———. Fraud against PSI, but, since “the charges arose out of the doctor’s almost total ignorance of how to keep accounts”, charges dismissed.
40. Dr. Robert J. Cardwell. Fraud against PSI. Suspended for three months.
41. Dr. Alfred Ian Rubenstein. Narcotics privileges withdrawn. Reprimanded.
42. Dr. ———. Permitting an unlicensed person to practise medicine on his professional premises. Suspended for three months. (Case under appeal, therefore name not published.)
43. Dr. ———. Five charges of exposing patients to unnecessary surgical hazards. Charges not proven sufficiently to constitute professional misconduct. Dismissed.
44. Dr. Walter Dirnberger (see case 5 above). Restored to Register.
45. Dr. Peter Ross Beacock. Improper association with a woman . . . etc. Placed on Special Register with full practice privileges.
46. Dr. ———. Submitting fraudulent accounts to a prepaid plan and an insurance company. But also found liable to suspension from the Register under Section 35 (2) of the Medical Act relating to mentally ill physicians. Registrar directed to take action under this section.
47. Dr. Harold M. Jost. Convicted of an indictable offence under the Criminal Code (not specified). Court had imposed a probationary period. College added a further two years probation: reports on his conduct to be made every six months.
48. Dr. Arthur H. H. Malcolm. Refusing to administer an anesthetic when requested by another doctor, forming a medical opinion on his patient without proper examination, and exposing the patient to unnecessary hazards by refusing to administer an anaesthetic. Guilty on first two charges only, and in view of mitigating circumstances: no penalty.
49. Dr. Gerald Albert Marin. Failing to attend a patient. Severely reprimanded.
50. Dr. ———. Fraud against PSI. Suspended for three months. In the event she did not make restitution to PSI within four months, name to be erased from the Register. (Case under appeal, therefore name not published.)

51. Dr. ———. Failing to make available to a patient proper medical attention. Not sufficient evidence to support a charge of professional misconduct. Dismissed.
52. Dr. Max Glassman (see body of text): Dr. Max Glassman was charged with professional misconduct in that he was alleged to have 1) rendered an account which was excessive having regard to the services performed; 2) distributed or caused to be forwarded to a certain industrial office a circular advertising his professional services and those of his medical centre. The Discipline Committee found him guilty on the second charge only and directed that he be reprimanded. This decision was appealed by Dr. Glassman to Council. Council directed that the matter be referred back to the Discipline Committee for rehearing. This decision was further appealed by Dr. Glassman to the Court of Appeal of Ontario who directed that the case be referred back to Council for a definite decision, holding that Council had no power under the provisions of the Medical Act to direct the Discipline Committee to hold a rehearing. In accordance with this decision, Council again heard Dr. Glassman's appeal, reversed the decision of the Discipline Committee and found Dr. Glassman not guilty of professional misconduct.
53. Dr. ———. Fraud against a prepaid plan. Dismissed.
54. Dr. George V. Berner. Failing to provide a patient with a reasonable explanation for his account. Reprimanded; to refund the overpayment.
55. Dr. ———. Charging a grossly excessive fee. Dismissed.
56. Dr. ———. Failing to attend patients. One year suspension of penalty "during which period (he) is to continue treatment under a psychiatrist". Reports to be made to Council every three months.
57. Dr. Kenneth Francis Walker, Niagara Falls, Ontario, was found guilty of professional misconduct in that he had made an unauthorized disclosure of information of a medical nature respecting a deceased patient to the distress of the patient's family. The disclosure was made in a story written by Dr. Walker and published in 1965 in a nationally circulated magazine; it related to an incident that took place in 1951 while Dr. Walker was temporarily employed as a ship's surgeon in the merchant marine prior to entering private practice. On the direction of the Discipline Committee a reprimand was administered by the Chairman of that Committee. Dr. Walker having appealed to Council from the decision and penalty of the Discipline Committee, Council heard the appeal on January 4, 1967 when it affirmed the decision and action of the Discipline Committee. The costs of and incidental to both hearings were assessed against him.
58. Dr. ———. Incompetence in the care of two patients. Dismissed.

59. Dr. Lorne Evans Carpenter. Improper association with a married woman. Struck off Register.
60. Dr. Strul Strulovici (see case 22, fraud). Convicted of criminal abortion. Name automatically erased from Register under Section 33 (5).
61. Dr. Martin W. Stapleton. Issuing a certificate relating to the mental competence of a patient "which certificate he knew to be false" and which he later repudiated. Reprimanded.
62. Dr. ——— made application for termination of suspension under Section 35 (mental illness). Placed on Special Register with full privileges.
63. Dr. ———. The same. Placed on Special Register with practice restricted to institutions.
64. Dr. ———, who had been erased from the Register in 1964 and subsequently registered on the Special Register without prescribing privileges for narcotics, made application for restoration to the Register with full practice privileges. The Committee being seriously concerned by Dr. ———'s attitude towards the use of narcotics in the relief of pain regardless of the risk of addiction recommended that his application be dismissed and this was concurred in by Council.
65. Dr. ——— (case referred to in body of text). The College having been notified, as required by Section 36 of the Public Hospital Act, that Dr. ———'s surgical privileges had been suspended because of an unusually high incidence of complications in a certain surgical procedure, the Discipline Committee was directed to hold an inquiry into Dr. ———'s professional competence in the field of operative surgery. The Committee heard evidence from the Chief of Staff, the Chief of the Department, the former chief of the Department, two consultants and an emeritus professor in the specialty. The hospital administrator gave evidence on the organization of the hospital, its staff, departments and by-laws. The Committee inquired fully into the cases in which the complications had occurred and the measures taken by the Department and the Medical Advisory Committee to deal with the situation. It also heard evidence from Dr. ——— on his postgraduate training and his explanation for the complications. It was concluded by the Committee that although Dr. ——— had had the required postgraduate training and was certified in the specialty concerned, he was not competent to do the procedure in question. From the evidence adduced the Committee found that although the Medical Advisory Committee had given Dr. ——— a hearing before initiating the initial restrictions on his privileges, it did not give him a further hearing in regard to later allegations that were made and which resulted in suspension of all his surgical privileges. The Discipline Committee criticized the Medical Advisory Committee for its failure in this last instance to observe the principles of natural justice.

The following recommendations of the Discipline Committee were adopted by Council:

- 1) That the Chief of Staff and Medical Advisory Committee should be instructed in and required to adhere to correct judicial procedure when taking disciplinary action.
- 2) A complete surgical audit should be carried out on Dr. ———'s work at the ——— Hospital.
- 3) Dr. ——— should have no major operative privileges in his specialty until he has taken an adequate participating postgraduate training course in these operative procedures.

The Council made the following comments in its Annual Report:

This case has directed attention to the respective responsibilities of the College and the Board of Governors of a hospital for the administration of disciplinary measures in respect to a member of the medical staff. The Public Hospitals Act gives the Board of Governors authority to discipline a member of the medical staff in so far as his hospital privileges are concerned; and to assist the Board in dealing with matters concerning the medical profession the Act has provided for a Medical Advisory Committee. There is no conflict between the authority given the Board of Governors by The Public Hospitals Act and that given the College by The Medical Act since the one relates solely to the doctor's hospital privileges and the other to his licence to practise. In fact the one is complementary to the other. *However, not only has the College a responsibility to protect the public from the incompetent doctor but it has a duty to its member to see that he has been dealt with equitably by his professional colleagues who constitute the Medical Advisory Committee.* On several occasions during the course of a Hearing or Inquiry held by the Discipline Committee the evidence has disclosed that the doctor has not had a proper or fair hearing before the Medical Advisory Committee reached a decision on its recommendation to the Board of Governors.

The College has neither the authority nor the intention to impose rules of procedure that Medical Advisory Committees are to follow in holding their inquiries but the College does feel that it is in a position to offer guidance in these matters and it has prepared an outline of the principles that should be observed by Medical Advisory Committees when enquiring into the professional conduct of a member of the medical staff. Since these Committees are part of the administrative machinery in the hospital the College suggests to Boards of Governors that they assure themselves that their Medical Advisory Committees have followed proper procedures in the investigation of these cases before arriving at the recommendation that is to be made to the Board. (Emphasis added.)

Chapter 11 Protecting the Patient

*A doctor must not allow himself to be influenced
merely by motives of profit.*

—International Code of Medical Ethics

Four issues relating to the protection of the patient are discussed briefly in this chapter: disputes between doctor and patient; the problem of the “teaching patient”; quacks and medical frauds; and the adequacy of the existing institutional means of regulating quality of medical care.

Doctor-Patient Disputes

One of the most remarkable changes in social attitudes that have taken place in recent times is that of the public towards the medical profession. From a position of virtual sanctity, the doctor has been pushed more and more on to the defensive. There has been a spate of critical writing, some of it of the popular “muck-raking” variety, but a great deal more of a cool and analytic kind, including important work by sociologists of medicine, some of them medically qualified, and by doctors engaging in professional self-analysis (such as the work of Clute on the general practitioner). General practice, medical education, the doctor in the hospital, medicine and the drug industry, the structure and informal workings of the profession, medical research, have all been subjected to some measure of critical scrutiny. Further, medicine has been a popular subject for the attentions of the mass media. The result is that, today, no other profession is open to so much public debate and questioning. The public expects accountability; the patient is more vocal and demands the right to information and the highest standards of professional competence. It is all the more surprising, therefore, that the machinery for settling disputes between doctors and patients (short of the cumbrous and expensive instrument of the courts) should have remained for so long in a rudimentary state.

As we noted in Chapter 2, the traditional basis of professional remuneration (at least notionally) was a free agreement between the individual professional and his client. In course of time, charges became fixed and customary; but today the common practice is for the profession itself, collectively, to draw

up a schedule of fees, graduated (roughly) according to the amount and difficulty of the work performed. That is the present situation in the medical profession in Ontario, though in a period of "creeping medicare" it is doubtful whether it can be maintained much longer. This is not to say that the "fee-for-service" principle necessarily will be abandoned; but it almost certainly means that the government insuring agency will come to demand a greater share in the fee-fixing process — which is precisely what the organized doctors fear.¹

In Ontario, the doctors' standard fees are set by the Council of the OMA, in form at least. They are, in fact, worked out in detail by the Tariff Committee and its sectional subcommittees and are then subject to ratification or rejection *en bloc* by the Council. Officially, the OMA says it

. . . publishes from time to time a Schedule of Fees which has been approved by Council. This schedule is used as a guide by the members in arriving at charges for services rendered; it is used also by insuring agencies in designing benefits in plans of medical services insurance.²

It is not entirely clear, either from Dr. Routley's history of the OMA or from other records, at what stage the collective setting of fees was begun; but in the published accounts of those early years (among the references to speakers at the scientific conferences advocating the prescription of a bottle-and-a-half of brandy a day for the treatment of carbuncles) we find indications that local societies were setting their own fees long before the OMA came into existence. So far as the OMA is concerned, we note that a resolution was put to the annual convention in 1914 calling for the creation of a Standing Committee to consider

. . . the question of fees in all its bearings, with a view to safeguarding the interests of the public and the profession, and making such suggestions for changes or adjustments as may be deemed desirable . . .

The preamble to the present Schedule of Fees states that it "represents a reasonable average return for services rendered", though the OMA "recognizes that there are circumstances where the scheduled fee would be inappropriate". We will not here embark on a lengthy discussion of this issue, because it belongs properly to medical economics (the subject of another report to the Committee on the Healing Arts). But something must be said about it, for disputes about

¹Just as there are "four and twenty ways of making tribal lays", so there are many ways of paying doctors — many more than is generally realized. They are discussed in a forthcoming book by Professor William A. Glaser of the Bureau of Applied Social Research, Columbia University, New York. I am indebted to Professor Glaser for letting me see a pre-publication draft. The book is provisionally titled *The Compensation of Physicians*.

²Evidence to the Committee on the Healing Arts.

fees are a potential (though by no means the only)³ source of work for the local mediation committees which the OMA sponsors.

The Tariff Committee of the OMA is selected to represent the various geographical areas and medical specialties in Ontario. It is thus the focus of pressures (not all of which are openly stated, even within the profession) which vividly illustrate the "pluralistic" nature of the medical fraternity. The Committee works out the parameters within which a detailed schedule can be arrived at: these are defined with regard to the cost of living, what is a "fair" remuneration (as seen by the doctors), what the insuring agencies are willing to pay, and so forth. (In determining these parameters, we were told, statistics gathered by PSI are used.) Within each section of the OMA there is a separate tariff subcommittee, the members of which appear before the main committee to argue for the special interests of their "constituents". Through processes of bargaining and adjustment the size and relation of the various fees are ultimately arrived at.

An important complicating factor relating to the tariff, coming increasingly to the fore in recent years and well recognized by the profession, is that it is almost impossible under modern conditions to write a Schedule of Fees that is acceptable to doctors in all specialties and in all areas of the province. At least one section and at least one local medical society have recently threatened to set up Schedules of their own. If the practice were to spread, it would constitute a grave threat to the authority of the OMA. The response of the Board of Directors has been to set up a special committee⁴ to look into the whole

³Fee disputes between doctor and patient perhaps become less likely as payment is increasingly transferred to insuring agencies. The following is the result of a study of complaints received by OMA Headquarters during the month of November 1966:

Re doctor's charges:

Billing above OMA schedule	26
OMA fee schedule too high	7
Improper billing procedure	7
Improper charges	4
Billing indigent patients (above OMSIP benefits)	3
Emergency medical services of hospital	2
OMA fee schedule too low	1
	50

Re doctor's services:

Refusal to complete insurance form	4
Refusal to make house call	2
Failure to keep patient informed of treatment	2
Refusal to talk to patient on telephone	1
Question re drugs prescribed	1
Keeping patient waiting long after appointment	1
	11

TOTAL 61

⁴Under the chairmanship of a Sudbury doctor. The members include: a Scarborough general practitioner, a surgeon from Hamilton, a general practitioner from Guelph and the President of the OMA.

question of what is now called "decentralization" of the tariff, and its implications for the profession and the OMA.

In general, the OMA argues that the Fee Schedule represents a minimum, not a maximum. The College of Physicians and Surgeons takes a different view. It firmly stands on the principle that in any agreement between doctor and patient, the physician's charges should be "reasonable" and he should abide by them. The College agrees, however, with the OMA's view that charges can properly take into account such factors as the qualifications and standing of the doctor, the degree of skill exhibited, the time taken on the patient, where and in what circumstances the service was performed (in the office or at the patient's home, day or night, emergency or routine), the geographical area in which the services were rendered, and even "the attitude and demands of the patient". But, without prejudice to these factors, the College's view is that the charge ought not to exceed (and may in fact be lower than) the scale fee published by the OMA. (One of our respondents reported that most of the doctors "disciplined" in mediation disputes were young doctors who had not become accustomed to the "sanctity" (sic) of the Fee Schedule.)

A somewhat uneasy compromise appears to have been reached after much debate. Both sides now agree that if the patient has no free choice of doctor (which, increasingly, in many areas, he has not) or if there is no prior understanding about a higher-than-scale fee, the scale fee should apply. But the College has recently reiterated its position:⁵ that it is essential that doctors adhere to the Schedule unless there exist special circumstances; and that in the event of a complaint the doctor shall be required to demonstrate either the special circumstances that warranted a higher fee in that case, or that a prior understanding with the patient did in fact exist. It is agreed, however, that such cases will go first to the appropriate local OMA mediation committee (see below); and that, if they cannot be settled there, they will not be referred to the Discipline Committee of the College until they have been considered first by the Complaints Committee of the College or by the Council of the College itself. The College says that a member "may be considered guilty of professional misconduct" if he

- 1) Fails to carry out the terms of any agreement with a patient or representations made to a patient as to his professional charges.
- 2) Makes a professional charge that is considered to be excessive in that it fails to take into consideration the factors outlined above.
- 3) Persists in making professional charges that fail to take into proper consideration those factors.

There remains an important difference of opinion here with the OMA; for, in a recent resolution, the Council of the OMA took the stand 1) that it was

⁵Report of the Council of the College, April 1967 (in Report of the College for July 1967, pp. 19-20).

only "desirable" that the doctor should "be guided by" the Fee Schedule, not essential that he should adhere to it; 2) that the onus of demonstrating a prior understanding with the doctor should rest with the patient and not with the doctor; and 3) that it should be optional, not mandatory, for the doctor to demonstrate "special circumstances" leading him to demand a higher-than-scale fee.⁶

The Mediation Committee machinery⁷ of the OMA dates from about 1952: at least, it was in that year that the Association asked each branch society to establish a committee. There is also an informal Central (Mediation) Committee, established by the OMA, which is actually the Executive of the OMA "wearing another hat"; but this serves, in the main, as the local mediation committee for complaints arising in the Toronto area.

The mediation committees have not worked well.⁸ Local societies have been reluctant to appoint them, and even where they exist, they have not always proved effective. We were told that the "defending" doctor usually appears, though he does not have to and, since the committee has no formal authority, he is under no compulsion to pay any attention to its findings. In such a case, the OMA may have no alternative but to refer the matter to the College. But this is not a satisfactory solution. To make a single fee dispute into a disciplinary case is rather like taking a steam-hammer to crack a nut. Indeed, it is by no means clear why the College should be asked to mediate in such cases. We have been told that another course of action open to the local committee which has been under discussion by the OMA (in our view equally cumbersome and unworkable) is that the patient should be told that, where he is found to have a case, the local committee will back him in court if he refuses to pay the "defending" doctor.

⁶The actual resolution (Transactions of Council, January 19, 1967) reads:

Whereas the OMA Schedule of Fees is recognized as a reasonable standard of value of professional services,

Be it resolved that it is desirable that doctors be guided by the Schedule as interpreted by the Committee on Tariff — particularly in circumstances where the patient has had no choice of doctor — unless there exist special circumstances which make the scheduled fee inappropriate to the particular case or unless there has been a clear prior understanding with the patient of the extent to which the doctor's fee would exceed the Schedule; and,

Be it further resolved that in the event of a complaint with respect to an excessive fee, the complainant shall be required to demonstrate to a Mediation Committee of the OMA that prior understanding with the doctor did not in fact exist or the physician may be required to demonstrate to a Mediation Committee of the OMA that special circumstances existed which warranted his fee.

⁷Complaints by one doctor *against another* may give rise to a disciplinary case; but in many instances they are referred to mediation by the Executive Committee of the OMA (the members of the Executive also form the Central Mediation Committee for patient-doctor disputes).

⁸This judgement is based not only on internally published material (such as the Reports to the Council of the OMA), but also on interviews we had with a number of prominent OMA office-holders.

The formality of the mechanisms for dealing with complaints varies widely among the local societies. For example, the Toronto Academy of Medicine refers all complaints to the OMA headquarters. Complaints received by the Hamilton Academy are referred to a committee composed of the president and the four immediate active past presidents. Like the OMA itself, the Academy requires that complaints be submitted in writing.

Mediation is handled on an ad hoc basis by the executives of the Leeds and Grenville and the Hastings and Prince Edward societies. The Leeds and Grenville society, in compliance with an OMA request, formalized this arrangement to handle one dispute which arose several years ago; but the mediation committee then formed has had no occasion to function since. The Hastings and Prince Edward society reports also that it receives few complaints, but this is probably due less to the absence of grievances than to the lack of any central receiving agency known to the public for registering them.

It was admitted⁹ that one of the problems about the local mediation committees is that of making sure that the public knows of their existence. They were referred to in the OMA's pamphlet on OMSIP, thousands of copies of which were distributed to patients via doctors' offices just before the scheme came into operation; and some local societies have tried to publicize their own committee (for example, Peterborough sent letters to the local trade unions).

But the real objection to the existing mediation machinery is more fundamental. It is doubtful, to say the least, whether it is in the public interest to leave the handling of disputes between patient and doctor to an informal and indifferently organized mechanism established by the profession itself, with no representation of the patient, and no apparent means by which the rules of natural justice may be safeguarded. Moreover, the ultimate sanction lies in the disciplinary power of the College, surely a very clumsy and inappropriate instrument for such cases.

The "Teaching Patient"

The problem of the "teaching patient" raises both practical and moral issues. The moral issues are beautifully illustrated in the following extract from a letter from a Baltimore doctor to the *New England Journal of Medicine*. The letter is so straight-faced that the irony is not immediately apparent, but the author's concern is evident. Explaining that he is describing a recent experiment in medical education at "the Baltimore Lying-Down Hospital", he continues:

Cases are presented by assistant residents who have never seen the patients before. This practice eliminates the annoying personal references that otherwise tend to creep into presentations and reduces the emphasis on individual, and thus idiosyncratic, aspects of the cases. Being completely ob-

⁹Interview with a former President of the OMA.

jective, the presenting resident need only offer the pertinent facts, with the laboratory data recorded on a slide, and avoid any distracting reference to other, less important features of the patient's disease

To facilitate the presentations and to avoid confusion in the audience, patients wheeled into the conference room are colour coded according to the category of disease into which they best fit. This is accomplished by the use of bathrobes in a number of colours, which are available on the wards and which are supplied the patients before their presentation. For example, a patient with heart disease wears a blue robe, one with a hematologic disorder, a red one, one with a gastrointestinal complaint, a brown one, and so on. Subclassifications are possible by arm bands and, in some complicated cases, by head turbans

More recently the Lying-Down Hospital has experimented with the use of masks to be worn by the patient during the time that he is being presented. To this end, the staff has found most suitable the classical Greek masks of comedy and tragedy whose symbolism is well known to most of the audience. If a patient is considered to have improved during the course of his stay in the hospital, he is given a comic mask to wear. Then, no matter the *facies* that he arbitrarily chooses to assume, it is obvious to the audience that he is feeling well. Similarly, tragic masks highlight a patient with a fatal disease even though he may feel temporarily healthy. Mere personality is, in this way, not a distraction to the audience, who, after all, are part of a learning experience and need to concentrate to their fullest upon the process being described. In this regard, in a few cases, even medical students or paid hospital workers have been substituted beneath the masks and, in this way, have been able to create interesting presentations that otherwise would not have been feasible. By the use of masks it has been possible to reduce considerably the number of patients admitted to the hospital since cooperative patients could be presented a number of times over without the audience's knowledge, and, in some cases, to avoid use of the patient at all¹⁰

The practical problems are matters partly of "medical economics" and partly of supply. On one aspect of the economics of the teaching patient, Dr. Laurence Wilson has this to say:

. . . private patients — and in the future all patients will be private patients in this sense — are not always an unmixed blessing to a teaching program. We have seen that the clinical teacher must be a self-effacing person who remains in the background and delegates as much responsibility as the house staff can assume. In fact, in a teaching hospital with a house staff developed to a reasonable level of complexity, there will be residents in their third and fourth year of graduate training who are quite competent to look after the care of most patients without any active participation by the clinical teacher — and they must be allowed to do so if their training is to progress. *But it will not be easy for the clinical teacher — especially the part-time clinical teacher — to remain in the background if his present and future income depends in large measure on his building up and maintaining a sizable private practice.* I suggest that this is the difficulty on which some teaching programs have foundered when they have tried to make use of private patients; certainly it is not

¹⁰*New England Journal of Medicine*, Vol. 278, February 8, 1968, p. 335.

unknown for the private patients' pavilion to provide the least rewarding clinical experience in a hospital. At the same time, there is a different but related hazard: that the clinical teachers, already backed by the prestige and security of their university appointments and given a sophisticated house staff to look after their patients and the control of teaching beds in which to house them, may in fact, fall heir to a closed monopoly which they may exploit at the expense of their colleagues in private practice. . . .¹¹

On the side of supply, the teaching hospital *must* increasingly rely on private patients (or more accurately, paying patients¹²), for with the virtual disappearance of the indigent and the coming of medical insurance, the "private" patient is the major source of teaching material. Since the production of doctors cannot continue without patients to learn on, the problem must be solved by encouraging more paying patients to "volunteer". At the same time, however, it is important to ensure that the manner in which the teaching patient is used by the hospital is as human, and as humane, as possible, and that his rights as an individual are fully respected. This is easier said than done.

Opinions differ about the extent to which patients generally are willing to be used as "teaching material". In the Hill and Wilson study of family practice in Hamilton, the patients were asked how they would feel about attending a clinic that was both a teaching and a research unit. (More specifically, did they think it was acceptable to attend a clinic where student physicians are being trained under the guidance of their own family doctor; and, second, did they feel it was acceptable to go to a clinic where research into the nature and cause of illness is being conducted?) Of those questioned, 79 per cent said they found the first proposition quite acceptable or had only some slight hesitation. Only 9 per cent were strongly opposed. On the second question (attending a clinic which is both a teaching and a research unit), 83 per cent found it quite acceptable, and only 6 per cent were strongly opposed.

As we have already pointed out, however, the Hill and Wilson study is in many ways untypical (the authors, of course, do not claim otherwise). Moreover, it refers to an outpatient clinic, not to an in-hospital situation (though the unit is part of a teaching hospital). Most doctors assert that patients are only too willing to be used for teaching purposes, sometimes to the point of embarrassment. They are willing, moreover, not only to be "taught on", but also to be experi-

¹¹*Ontario Medical Review*, March 1964, pp. 201-202. Emphasis added.

¹²Some insurance schemes, of course, provide for semi-private or private accommodation on payment of additional premiums; the beneficiaries of these, properly, are the private patients. Most paying patients are housed in public wards. There is, also, in practice (in some areas — chiefly the large urban areas) a third category of patient: the insured patient who arrives at the hospital without any doctor (i.e., the patient who "refers himself"). This, in practice, may be an important source of "teaching material", or as some would put it, more bluntly, "teaching fodder".

mented on.¹³ This is a matter that requires greater attention than we were able to give. Evidently patients are not always informed unambiguously, on admission, that they *are* going to be "taught on". And they do not always know what they are undertaking when they do agree. Sometimes the "choice" is not a real one. To quote Paul Ferris again:

The fiction at some teaching hospitals is that patients are always asked if they mind, and it is true that (on arrival at the bedside) the consultant . . . may murmur cheerfully: "These young chaps have come to look at your tum — don't mind, do you?" But this is hardly the same thing.¹⁴

A complex of factors, socio-economic, psychological, institutional and moral, is involved in any analysis of patient cooperation. We are all too familiar with the patient who is willing to talk endlessly about his symptoms and treatment, not only to his fellow patients, but to any doctor, nurse or medical student he can cajole into listening. Willingness to cooperate is related also to social class, and associated factors such as education and job. Hill and Wilson found that 67 per cent of those doubtful about, or strongly opposed to, attending a teaching clinic had an education of Grade Ten or less and that 63 per cent of those responding positively were in "high" ranking occupations. In other words the better the job and the greater the education (the more "middle-class" the patient), the more cooperative the patient was likely to be. Young men were likely to be more cooperative than older women (the "positive attitude" group was 69 per cent male, 31 per cent female, and 66 per cent of the group was aged forty-six or less). The peculiar moral and psychological pressures induced in the patient once he is inside the hospital also require investigation. Just as "no man can argue on his knees" (Bagehot), so, perhaps, no patient can argue with his clothes off.¹⁵ In brief, patient "cooperation" is part of a whole complex making up the "sick-role" in Western society. One aspect of this is the degree of willingness with which the patient places himself unreservedly in the hands of the doctor; and we know (in a general way at least) that persons of different socio-economic backgrounds and psychological type will play this aspect of the sick-role differently. The role is socially, institutionally and individually determined; and we still have much to learn about it. Until we learn more, we can scarcely expect to "solve" the teaching-patient problem satisfactorily — that

¹³There has been much recent writing on medical experimentation using "human guinea-pigs". Time, unfortunately, did not allow us to pursue this. The dilemma has been put, in a nutshell, by Sir Robert (now Lord) Platt: "It is difficult to say whether the man who first did a percutaneous liver biopsy displayed great moral courage or an unusual indifference to his patient's welfare, yet it has proved a valuable means of diagnosis." But, he continued, "There are clinical investigators whose . . . attentions I would studiously avoid." Unfortunately, the average patient does not have Lord Platt's knowledge of the medical profession to aid him in deciding whether or not to sign the form releasing the investigator from responsibility.

¹⁴Paul Ferris, *op. cit.*, p. 44.

¹⁵Compare "nude therapy" — a form of psychotherapy given public prominence in a 1968 edition of the CBC program, *The Way It Is*.

is to say, in a thoroughly humane and ethically defensible way. Meanwhile, no doubt, patients will continue to be bamboozled, "soft sold" and subtly pressured into "volunteering" their services.

Quacks

The Concise Oxford Dictionary defines a "quack" as: "an ignorant pretender to skill, especially in medicine and surgery, one who offers wonderful remedies or devices, a charlatan." The Medical Act of Ontario attempts to deal with some aspects of this problem by prescribing penalties for "wilfully or falsely pretending to be a physician, doctor of medicine, surgeon, or general practitioner" (Sec. 52) and for "practising medicine, surgery or midwifery for hire, gain or hope of reward" when not on the Medical Register (Sec. 51). The College usually prosecutes two or three cases a year.¹⁶ There is a minimum fine (on both of these counts) of fifty dollars for a first offence; a minimum fine of \$200 for a second offence; and a minimum fine of \$1,000 and a minimum of six months' imprisonment for a third and subsequent offences. The cases that are brought to trial are those that are almost certain to result in a conviction, and even then minimum sentences are usually imposed. Prosecutions must be brought within a year of the alleged offence; and it has been difficult, in practice, to prove to the satisfaction of the courts that a single occurrence constitutes illegal practice, and that "hire, gain or hope of reward" was involved. The College has asked for the Act to be amended to remove these difficulties.

A further clause in the Act (Sec. 53) prohibits the use of any title or description that implies, or is calculated to lead people to infer, that an unregistered person is registered under the Act; and it also prohibits the use by unregistered persons of titles such as "Doctor", "Surgeon" or "Physician". There are loopholes in this clause too which the College wishes to close, and it seeks to add the word "Specialist" to the list.

It might appear at first sight that this is a straightforward issue. In fact, it raises some very fundamental problems. The practical ramifications include the definition of the practice of medicine, the question of "protected titles", and (indeed) the whole matter of the licensing process.

It is possible to distinguish between *registration*, which involves the listing by some authoritative source of the names of all "qualified" practitioners; *certification*, which involves a mere recognition of certain skills (for example, anyone can be, and call himself, a barber but only members of the Barbers' Associa-

¹⁶The Registrar told us of one recent case of a person who actually applied for registration, submitting false credentials! These cases fall under Section 50 (obtaining registration by fraud). Cases of practising without registration usually come to light through insurance claims, though another fairly frequent source is women who complain about the way they have been examined.

tion can put the letters M.B.A. after their names¹⁷); and *licensing*, which implies that it is illegal to operate without the appropriate document. Various combinations are possible. For example, in Britain you can call yourself a "Registered Architect" only if you have passed the examinations of, and been registered by, the Royal Institute of British Architects: i.e., "Registered Architect" is a protected title; but there is nothing to prevent you from doing everything an architect does so long as you call yourself something else. Licensing itself may take several forms: it may be restricted (such as the Ontario Education Register); it may be limited (some doctors on the Special Register cannot prescribe dangerous drugs); or it may be vocational (the holder being licensed to practise a particular branch of medicine only).¹⁸ "Full" registration in Ontario is, in principle, general licensing. British medicine has both certification and registration, but not licensing; that is, it is not illegal to "practise medicine", and anyone can call himself a doctor, without being registered under the Medical Acts:

. . . medical certificates signed by herbalists and nature-curers are thoughtfully accepted by . . . officials, in recognition of the individual's right to be treated by whoever he pleases. But the non-qualified (and registered) doctor cannot sign a death certificate, prescribe dangerous drugs, or work for the National Health Service, and he runs the risk of prosecution for manslaughter if the patient dies.¹⁹

Certificates by "proper doctors" are always signed "John Smith, Registered Medical Practitioner", never "Dr. John Smith".

There are, then, a number of elements involved. Appropriate "letters" after the name (certification) distinguish (or presume to distinguish) the qualified from the unqualified, assuming that the consumer knows what they mean. But registration (if not licensing) by the State is the goal of almost all modern professional organizations: it makes possible complete regulation of entry to the "recognized" profession; it facilitates the disciplining of the membership and makes internal, professional rules easier to implement; it gives the profession and its qualifications the stamp of public approval; it raises the status of the members and hence, perhaps, their earning power; and (economists would argue) it helps limit the availability of substitutes for their services.²⁰ Moreover, since

¹⁷This is a fictitious example.

¹⁸South Africa is a pioneer in vocational licensing for medicine.

¹⁹Paul Ferris, *op. cit.*, p. 16. In Britain, at least until quite recently, registration Acts seem to have been based on the principle that the public ought to be free to choose between qualified and unqualified practitioners, the assumption being that they knew which was which. While in London preparing this report, the author heard of a distinguished doctor who appeared before a Parliamentary Committee. Seeing that he was suffering from psoriasis, one of the M.P.'s remarked: "You ought to go to a woman in Kent. She has bees that have a special sting. She'll cure you."

²⁰Registration and licensing are not, of course, the only devices tending to professional monopoly. This may come about, for example, where there is a very large or even monopsonistic buyer (like the State), or where a statute prescribes qualifications for certain jobs. For example, a statute may prescribe that only chartered accountants may audit the accounts of public companies.

registration is nowadays sometimes used to regulate the proliferation of *different* qualifications, it may help to protect the client or customer in a manner not foreseen by the pioneers of State registration.²¹

But this is not the end of the matter. On the contrary, the fundamental questions are those relating to the *scope* of a profession and the *nature* of the skills it professes and hopes to protect through State registration. In this case, how does one define "the practice of medicine"? In the last analysis (and this is true of the practice of most major professions) it is defined by reference to institutions and organizations: the practice of medicine is what licensed doctors *do*. Thus, by definition, anyone not licensed and anyone explicitly exempted is falsely claiming to practise medicine.

In point of fact, there *is* no definition of the practice of medicine in the Ontario Medical Act.²² This lack, the Ontario College of Physicians and Surgeons urges

. . . complicates, and sometimes frustrates enforcement of the fundamental purposes of the Act: the protection of the public against unregistered *and hence unqualified* persons.²³ (Note the assumption that unregistered means unqualified.)

The College's task of seeking out "unscrupulous quacks and fakers" is rendered all the more difficult, it is argued, because it has come to be regarded

. . . in some quarters as a vested body that seeks to persecute the members of other groups for its own selfish ends. The fact is obscured that these limitations upon the rights of practice were imposed for the protection of the public and not for the benefit of the members of the College.

This, however, begs the question: "What is the scope of the practice the College seeks to safeguard?" Does it, or does it not, for example, include the skills claimed by groups such as chiropractors, osteopaths, podiatrists and naturopaths? The medical profession is more than a little inconsistent here. On the one hand, it accuses (some of) these groups of professing a false science; on the other, it accuses them of doing things that only a doctor is qualified to do.

The College has requested that a definition of the practice of medicine similar to that accepted in British Columbia be included in a revised Medical Act. The relevant section of the B.C. Medical Act reads as follows:

It is not lawful for any person not registered under this Act or who is suspended from practice to practise or to offer to practise medicine, surgery, or midwifery, and without in any way limiting the generality of

²¹I.e., registration may be necessary to distinguish between a plethora of qualifying bodies with competing qualifications (competition *within* a profession).

²²There is in Nova Scotia, Quebec, Manitoba, Saskatchewan, Alberta and British Columbia.

²³Supplemental Brief submitted to the Committee on the Healing Arts. Emphasis added.

the foregoing a person shall be deemed to practise medicine within the meaning of this Act who

- (a) by advertisement, sign, or statement of any kind, written or verbal, alleges or implies that he is, or holds himself out as being, qualified, able, or willing to diagnose, prescribe for, prevent, or treat any human disease, ailment, deformity, defect, or injury, or to perform any operation to remedy any human disease, ailment, deformity, defect, or injury, or to examine or advise upon the physical or mental condition of any person; or
- (b) diagnoses, or offers to diagnose, any human disease, ailment, deformity, defect, or injury, or who examines or advises upon, or offers to examine or advise upon, the physical or mental condition of any person; or
- (c) prescribes or administers any drug, serum, medicine or any substance or remedy for the cure, treatment, or prevention of any human disease, ailment, deformity, defect, or injury; or
- (d) prescribes or administers any treatment or performs any operation or manipulation, or supplies or applies any apparatus or appliance for the cure, treatment, or prevention of any human disease, ailment, deformity, defect, or injury; or
- (e) acts as the agent, assistant, or associate of any person, firm, or corporation in the practice of medicine as hereinbefore set out.

Even a layman can see at once that such a definition raises as many problems as it settles. "The practice of medicine" has to be defined widely, for the medical art is wide. Yet to do so without qualification leaves open to possible prosecution a vast range of acts of a wholly innocent and innocuous kind. It immediately invites pressures from interested parties to obtain exemption from the relevant provisions of the Act. And it may even be argued that it is not, in the end, to the advantage of the medical profession to define its scope, since this may lead (though in a roundabout way) to public recognition of precisely those groups that the profession wishes to exclude. It should be noted that the Section of the British Columbia Medical Act just quoted continues:

. . . but this section does not apply to the practice of dentistry or pharmacy, or to the practice, under the direction or supervision of a person registered under this Act, of a psychologist, physiotherapist, or dietician, or to the usual business of opticians, or to vendors of dental or surgical instruments, apparatus, and appliances, or to the ordinary calling of nursing, or to the ordinary business of chiropodist, or bath attendant, or to the proprietor of a bath, or to any chiropractor acting within the scope of the Chiropractic Act, or to any naturopathic physician acting within the scope of the Naturopathic Physicians Act.

Moreover:

Nothing in this Act prevents (a) any person from giving necessary medical or surgical aid in case of urgent need if such aid is given without hire, gain or hope of reward (Author's note: we have already seen that this phrase leaves many loopholes): or (b) the domestic administration of family remedies. (Sec. 72)

And:

Nothing in this Act contained applies to or affects those who practise the religious tenets of their church without pretending a knowledge of medicine or surgery. (Sec. 73) (Author's note: which may be circular.)

The matter of "protected titles" is a little different (even Britain, which makes no attempt to license doctors, has a protected titles clause).²⁴ In particular, the College would like to see the use of the title "Doctor" restricted to medical practitioners. Their "public interest" arguments in supporting this claim are not always convincing.

It is unlikely that the average lay person would distinguish between the professional qualification of "Dr. John Jones, Optometrist", and "Dr. John Jones, Ophthalmologist", though there is a wide gulf between them²⁵

This is implausible. Most people know what an "optometrist" is.²⁶ The more likely result is not that they will mistake the optometrist for a doctor, but that they will think "ophthalmologist" is just a fancy name for an optometrist. Perhaps that is what the College has in mind; but it does not say so publicly. The more fundamental issue, in our view, is that of the prostitution of qualifications. The title "Doctor", by long tradition, has come to signify an academic qualification granted by a university or body of similar standing. Its indiscriminate use is objectionable, not because it implies that the user belongs to one profession (medicine) — which it certainly does not — but because it may be taken to denote a standard of professional achievement far above that which the user has actually reached, or was ever expected to reach.²⁷

There is, however, a case for the unequivocal use and, therefore, registration, in the medical and related professions, of such specialist titles as "psychiatrist", "psychologist", "radiologist", and so forth. The main difficulty here is that infringements are extremely hard to detect and suppress.

Quality Control

The adequacy of the existing controls on medical care was touched on briefly in Chapter 10. "Medical care" is only part of a wider concept of *total patient*

²⁴Section 31 of the Medical Act 1956 (4 and 5 Eliz. 2, Ch. 76) reads in part: "Any person who wilfully and falsely pretends to be or takes or uses the name or title of physician, doctor of medicine . . . surgeon, general practitioner . . . or any name, title . . . implying that he is registered under any provision of this Act, or that he is recognised by law as a physician or surgeon . . . (etc.) shall be liable upon summary conviction to a fine" The BMA told us that it would like the GMC to have the Act amended to list other titles (such as "psychiatrist") which are at present used by persons who are not registered medical practitioners.

²⁵College Supplementary Brief.

²⁶In any event, this issue (of public confusion over professional designations) could be tested empirically, without undue difficulty, by taking a sample survey.

²⁷The designation "Doctor of Surgical Chiropractic", for example, is preposterous.

care, though it is sometimes erroneously equated with it partly because of the rather nebulous notion that, in the last resort, doctors are ultimately responsible, in some sense, for everything that happens to the patient.²⁸ This may be so (though it is certainly open to argument); but it goes without saying that, within the hospital, the patient is subject to very many influences and the attentions of very many people other than doctors, which may profoundly affect the course and outcome of his illness.

A basic minimum "control" of total patient care is provided by means of the accreditation procedures of the Canadian Council on Hospital Accreditation.

The work of establishing standards for hospitals and administering a voluntary accreditation scheme based upon them was begun about fifty years ago by the American College of Surgeons. By the 1950's the great expansion of Canadian hospitals was under way,²⁹ and in 1954 a Joint Commission on Accreditation of Hospitals was established, representing hospitals and the medical profession in Canada and the United States. The next step was taken in 1958 when the CCHA was chartered under federal law, supported financially by grants from the federal government and by contributions from the founding organizations: the Canadian Hospitals Association, the CMA,³⁰ the Association of French-speaking Physicians of Canada, and the Royal College. The CCHA took over the functions previously exercised in Canada by the Joint Commission. Federal grants-in-aid were discontinued in 1965, and the Council now relies on support from its member organizations and fees collected from each of the hospitals surveyed.

The Council is an independent, non-profit corporation and accreditation is entirely voluntary. It cannot inspect a hospital except at the hospital's request, it has no disciplinary powers, and there is no compulsion in any of its proceedings beyond withdrawal of the certificate of accreditation. Nevertheless, most of the major hospitals in Canada are now accredited. Table 10, supplied by the Council, shows the position in Ontario as it was at December 31, 1966.

When the CCHA took over in 1958, about eighty Ontario hospitals were accredited. The number had grown to 103 by 1963 and to 112 by 1965. As can be seen from the table, the majority of general hospitals still without accreditation are hospitals with less than 100 beds.

²⁸For example: "Because a hospital is a place for *medical* care of patients, all other disciplines of order (sic) in a hospital surround and are directed to fulfill the doctor's orders for investigation and treatment." This contention was put forward by the Canadian Council on Hospital Accreditation in a brief to the Committee on the Healing Arts. It is of dubious validity, both empirically and normatively.

²⁹See Chapter 1.

³⁰Matters within the orbit of the CCHA are referred to the CMA Committee on Hospital Service and Accreditation. The OMA Committee on Hospitals performs a similar function within Ontario.

TABLE 10

Hospitals in Ontario: Accreditation by Size and Type, December 1966¹

Bed Size	General Hospitals			Long Term Care Hospitals (TB, Chronic and Convalescent)			
	Accredited	Not Accredited	Total	Accredited	Not Accredited	Total	Grand Total
Up to 99 beds	22	68	90	5	6	11	101
100-299	44	15	59	9	12	21	80
300-599	29	—	29	3	1	4	33
600 beds and over	14	—	14	1	1	2	16
	109	83	192	18	20	38	230

Total Accredited: 127

Total not Accredited: 103

¹Omitting mental hospitals, new hospitals not yet in operation or not in operation a full year, and hospitals under fifteen beds.

To be accredited, a hospital must meet the Council's standards in five main areas of operation: physical plant, medical staff organization, nursing services, hospital government and administration, and essential services such as (in general hospitals) emergency, laboratory, medical library, medical records, pharmacy, and radiology. In 1968 the Council had about twenty medically qualified surveyors (they give their services voluntarily and are frequently medical directors of hospitals with some training in hospital administration), and a single surveyor normally carries out each inspection. The hospitals are resurveyed regularly every two or three years, but they may be resurveyed at any time "for cause". Several hospitals have, in fact, lost their accreditation.

Hospitals are rated Accredited, Provisionally Accredited and Not Accredited. In the second case, deficiencies are listed and must be made good before a certificate of accreditation is issued; a resurvey may be made after about a year. A non-accredited hospital is given a list of shortcomings; and when the hospital thinks it has overcome them, it may reapply for recognition.

The feeling was expressed at one hospital we visited (Toronto General) that the accreditation process is a formidable one, and that the various inspectors had particular areas of interest that they stressed more than others. It was felt that some of the rules are too hard and fast. However, the smaller hospitals tended to praise the "flexibility" of the standards, and we even heard some views expressed that they were too flexible! In general, however, there was little but praise for the Council and its work, and there is no doubt that the accreditation program has

done much to raise the general standard of patient care in Canada over the past twenty years. The patient can at least be assured that an accredited hospital is one in which certain basic minimum standards are met — which is all that the Council sets out to achieve.

We have seen that part of the official rationale of medical staff organization in the hospital is that it contributes to the maintenance of these standards.

At the present time a patient seeking care in a hospital has the assurance that the doctor treating him has privileges in keeping with his training, experience, judgment and competence; that a medical advisory committee is supervising the quality of medical services rendered in the hospital; that all cases where tissue has been removed are reviewed by a committee of the medical staff; that proper records are kept; and that the College of Physicians and Surgeons of Ontario has authority to deal with negligence or incompetence on the part of any member of the medical staff.³¹

Interpreted literally, this is, in almost all respects, an overstatement (and might well evoke wry smiles from members of the profession). The machinery is *aimed* at securing that, so far as possible, the doctor in the hospital has privileges in keeping with his competence, but in practice it is acknowledged to be far from infallible; the supervision of quality of care by medical advisory committees often leaves much to be desired; the effectiveness of medical audit and tissue procedures is conditioned by pressure of work and staff shortages; and, although great improvements have been made, it is well recognized that medical record keeping is still far short of what it should be.

The Hall Commission recommended that provincial hospital insurance agencies, the CHA, the CMA and the Association of French-speaking Physicians should "expand their efforts to encourage professional activities studies" similar to those made by the Hospital Medical Records Institute.³² The work of provincial medical associations (such as that of the OMA on mortality in operative procedures) was not specifically mentioned. It has already been suggested (in Chapter 10) that the advent of electronic data-processing such as is now provided (though as yet on a modest scale) by HMRI constitutes a great step forward. In a sense this is a continuation, though on a wider front, of the pioneering efforts of the OMA Committee on Mortality Associated with Operative Procedures.

This Committee was set up at the request of the Ontario Department of Health about ten years ago. The OMA reports that its functions are

To review —

(i) All fatalities occurring within twenty-fours of induction of anaesthesia, general or local;

³¹Supplementary Brief from the Ontario College of Physicians and Surgeons to the Committee on the Healing Arts.

³²*Report of the Royal Commission on Health Services*, Vol. I, Queen's Printer, Ottawa, 1964, p. 53; Recommendation No. 96.

- (ii) All fatalities involving patients not recovering consciousness post-operatively;
- (iii) Accidental happenings (cardiac arrest, fires, explosions, etc.) not necessarily resulting in fatality but from which useful information might be forthcoming.

In order to preserve anonymity, hospitals are referred to by a code number and no details of identification (dates, patient's name, name of surgeon and anaesthetist, and so on) are revealed to the committee. It is emphasized that the functions of the committee are fact-finding and educational only, and it does not act as a disciplinary body.

The Committee's work results, in many instances, in the publication of articles in the *Ontario Medical Review* "which it is hoped will be helpful to all those engaged in the care of patients requiring operative procedures". Studies completed or commissioned include: hemorrhagic shock related to operative procedures; operative deaths occurring in surgical procedures on children; the role of the anaesthetist in the avoidance of operative deaths; some aspects of the treatment of carcinoma of the rectum; and the role of the recovery room in the avoidance of operative deaths. The Committee's first statistical study, "Some Operating-Room Deaths are Preventable", was published in November 1961 and since then, well over two thousand questionnaires have been completed by hospitals for the use of the Committee. Because of the increasing complexity of surgical and anaesthetic procedures, as well as the increasing number of questionnaires completed each year, the Committee has now developed a form which can be used for computer tabulation.³³ The Executive Director of HMRI is a member of the Committee.

HMRI (the Hospital Medical Records Institute) is a non-profit data-processing service set up in 1963. It is sponsored by the OMA, the OHA and the Ontario Association of Medical Record Librarians; and, although its activities are not confined to Ontario, most of the subscribing hospitals are, in fact, located in this province. About seventy hospitals in Ontario representing about 40 per cent of the province's acute general beds now use its facilities. (It is understood that some — for example, Hamilton Civic — use the facilities of the Commission on Professional and Hospital Activities which is located in Ann Arbor, Michigan. This body, however, adopts a very different kind of philosophy towards the use of statistics in the control of medical care.)

The Institute, whose offices are in the OHA headquarters building in Toronto, buys computer services and time from the OHA. The Director told us that the Institute is now using over half the OHA computer centre time. Interhospital comparison is not one of the objectives of HMRI (as it is of CPHA). Studies are geared to the local level. The Director stresses that no two communities are alike in their physical composition, health needs and levels of medical practice, and

³³Information from the OMA.

he is sceptical, for this reason, of the value of intergroup comparisons. He maintains that one of the important responsibilities of the Institute is to prevent the abuse of data: "People tend to accept data at face value without giving sufficient attention to the underlying factors."³⁴ Enrolment in the program is contingent on a request from the medical staff of the hospital and the approval of the appropriate governing body. A wide variety of data can now be extracted from the records, and data, when processed, are available only to the hospital, unless the hospital specifically authorizes their release. Basically, says the Director:

HMRI is intended to provide the medical staff with a tool to assist them in evaluating quality of medical care. Whether or not doctors are using this tool is a matter for local determination by the hospital medical advisory committee, administrator and hospital board of governors. But we are confident that the more data of this nature we place in the hands of doctors, the more quickly they will learn to incorporate the data into study patterns

What HMRI has done, in effect, is to develop a coding system considered to be of value to the doctors, administrators and medical record librarians at the local level. The most important consideration applicable to the HMRI or any other program in use in a hospital is that the accumulation of the data is useless unless it is put to work

The HMRI philosophy is to provide consulting services at the local level to assist in the best utilization of this data

And HMRI can be just as useful to a 25-bed hospital as to a 1,000-bed institution.³⁵

The basic philosophy of the Institute is clearly stated in the preface to the Code Manual which is used by all participating hospitals. This is that data alone cannot and should not be used as a stamp of approval or disapproval of medical practice:³⁶

Something else is necessary . . . a knowledge of those factors which constitute the complexities of medical practice and their influence at the local level. This is why only doctors can fully attempt to assess medical care³⁷

³⁴Interview with the author, February 1968.

³⁵Feature Report in *Hospital Administration in Canada*, May 1967.

³⁶This is obviously correct; to give a grossly oversimplified example: a surgeon's operating death rate is meaningless unless we know diagnoses, age and condition of patients, and many other things besides. If a more "realistic" example is required, consider the following from the Port Arthur hospitals: HMRI reports were used to identify and study inguinal hernia procedures. Data were graphed according to length of stay, days stay by surgeon, and days stay by age group. One surgeon was found to be discharging patients comparatively early. This case was considered justifiable, however, because the patients were children. In two other instances, surgeons whose patients were shown to have unjustifiably long stays were "spoken to privately" and "have since reviewed their practice in this area". Statistics may indicate that something is wrong and provide clues as to where to look for an answer. "Bare statistics may tell only half a story and it may well be that the unmeasured factors overrule any apparent result derived from the statistics," W. J. Reichmann, *Use and Abuse of Statistics*, Penguin, Harmondsworth, 1964, p. 50.

³⁷HMRI Code Manual, pp. 1-2. But they may also need expert statistical advice.

Rudimentary though the present machinery may be for assessing patient care (and medical care as an aspect of it) *within the hospital*, the regular assessment of quality of care *outside the hospital* is almost non-existent, except as developed for rather limited purposes by the insuring agencies. The quality of medical practice outside the hospital is, of course, exceedingly hard to measure. Even within the hospital, devices such as HMRI are instrumental only in gauging medical care in the strictly technical sense — little or no account is taken of the needs of the patient as a person. Yet “quality” implies some standards that are not exclusively technical; and the criteria become proportionately less technical as we move into outside practice. They also become more difficult to measure. Outside practice, particularly general, or family practice, raises questions of measurement of such things as continuity of care, success in handling emotional problems, early diagnosis (i.e., of diseases the patient is not even aware of) and prescribing of drugs, all of which are more or less technical; but also of others, such as the accessibility and personal approachability of the doctor, and the social manner in which he handles the patient, which are only indirectly technical, if indeed they are technical at all. Technical criteria are difficult enough to establish (those that are used tend to relate to established investigational procedures currently accepted in medical schools — such as procedures for clinical examination and history-taking);³⁸ non-technical criteria (i.e., *objective* measures of patient wishes, needs and legitimate expectations) are even harder to set up. Moreover, much remains to be done to develop measures of the *effectiveness* of investigation and treatment as an aspect of quality, a more difficult task still and one that has been almost totally neglected.

This is a complex problem which we have had neither time nor competence to explore fully. All we can do is to draw attention to its importance, both for doctors and their patients, in its implications for the future of medical practice.

³⁸Dr. Clute attempted to include other factors in his measurement of quality of general practice (such as prescribing, general therapeutic advice and — to a limited extent — practice of preventive medicine); but even he placed great emphasis on the accepted diagnostic procedures of history-taking and physical examinations of the patient. His tests of quality were history-taking, physical examination, laboratory procedures, therapy, obstetric care, preventive medicine practised, and record keeping — all technical criteria, in the sense in which the term is used here. Most studies of this type since Lord Taylor's *Good General Practice* in the early 1950's have adopted more or less arbitrary criteria of what constitutes “good general practice” (in his case, these were what happened in practices that were thought good by other doctors).

Part Four: The Impact of Organized Medicine on the Health Services

Introduction

From the standpoint of the policy-maker, no very clear line separates medical education, medical research and medical practice. Consequently, the arrangement of topics in the next three chapters is somewhat arbitrary at times: a matter of convenience rather than logic. Further, it is almost inevitable that this part of the report should seem less specifically "Ontarian" than the rest, because the contemporary issues of medical education and research — and to a lesser (though still substantial) extent, of medical practice — are national, and even international, rather than solely provincial. By the same token, it would be meaningless to discuss such problems as *are* purely Ontarian out of the wider context.

Chapter 12 Medical Education

... for vast is the scope of our Art
—Maimonides' Prayer

In this chapter we look at issues and problems concerning undergraduate, post-graduate and continuing medical education, beginning with some comments on medical school facilities and staffing.

Educational Facilities

Enrolment in Ontario medical schools is expected to rise by about a third by 1970-1971 (over the 1960-1961 level) and by about two-thirds by 1975-1976.¹ A major increase in graduate work is forecast: the number of candidates for master's and doctoral degrees is expected to quadruple by 1975. A substantial expansion of effort also is envisaged in continuing education.

It is often assumed, by people in the health professions as well as by the general public, that there is a large untapped reserve of potential medical students. The studies by Fish, Clarke and Macleod are thought to have cast doubt on the

¹The Health Sciences in Ontario Universities, Committee of Presidents of Universities of Ontario, June 1966.

assumption, because they show that the number of "fully qualified" applicants who are refused admission to existing medical schools is actually quite small. As we saw in Chapter 8, however, this argument may be misleading. We need more information about medical school admission practices; we also need to know more about the motivation of school leavers: what attracts them to, or repels them from, a career in medicine. We know that only thirty-six "fully acceptable" applicants in 1965-1966 failed to gain a place in a Canadian medical school: what we do not know is what, precisely, "fully acceptable" means, and why there were not more good applicants in the first place. The enrolment rate per million of population is higher in Ontario than in all but sixteen of the United States (including the District of Columbia), but it is *lower* than in three of the Canadian provinces (Alberta, Manitoba and Quebec) and higher than only British Columbia and the four Atlantic Provinces. There is need both for more research on the problem of recruitment to medicine² and for energetic measures on the part of the provincial government and organized medicine to improve the present situation.

The expansion of medical school facilities and the pressure to increase the output of doctors of all kinds underline the urgency of the need for more and better-qualified medical teachers and medical scientists. The case has been dramatically presented by Dr. John Evans, Dean of the new medical school at McMaster and author of the Health Science report referred to above.³ In an interview with the *Toronto Globe and Mail* medical and science correspondents he said:

If we drew all our candidates from the postgraduate programs that are available in Canada and if every one of them was of satisfactory calibre and went into the Health Sciences, we still wouldn't have enough people to fill all the jobs that are being opened up and budgeted for in the Health Science program of the Ontario universities over the next five years.⁴

We know that there is a substantial annual loss of teachers and medical scientists to the United States (perhaps of the order of 20 to 30 per cent). We know that in creating new medical schools and expanding old ones there is little

²Among the barriers to recruitment frequently cited are

- 1) The high cost of a medical education, in terms of both actual monetary outlay and rewards foregone during the relatively longer non-productive years of preparation for the career.
- 2) Educational deficiencies in high school education (this is partly a geographical problem — i.e., deficiencies are greater in some parts of the country than others, and in some communities more than in others).
- 3) Motivational influences, such as competition from the more prestigious (?) natural sciences, increasing governmental regulation of medicine (?), etc.
- 4) Poor public relations on the part of the medical profession including the medical schools.

³*The Health Sciences in Ontario Universities, op. cit.*

⁴*Globe and Mail*, Weekend Magazine, September 24, 1966. The interviewers were Joan Hollobon and David Spurgeon.

point in "poaching" existing Canadian faculty. We know that the chance of attracting able Americans is relatively slight, given the highly attractive "research environment" existing in their own medical schools. We know too that the British, who are faced with similar problems, have recently been making great efforts to "recapture" their emigrant medical scientists and slow up the rate of movement to the North American continent.

To date, heavy reliance has been placed on Britain as a supplier of medical teachers and scientists; and if a 1965 estimate of the Canadian "stock" of medical school faculty (about 1,200) was right, it would appear that approximately a quarter of it was British. Much light has been thrown on this phenomenon in a recent study by Dr. T. C. Gibson.⁵ The study showed that in 1965 there were 669 British doctors on medical school faculties in North America. Of this number 327 were in Canada. Only eighteen of those in Canada failed to respond to Dr. Gibson's inquiries. British doctors were found on the staff of all but two of the twelve Canadian schools and the majority had emigrated in the decade 1950-1959, as the following tabulation, taken from the study, shows:

Dates of Emigration to Canada		
	<i>Full-time</i>	<i>Part-time</i>
Before 1945	4	1
1945-49	13	26
1950-54	29	70
1955-59	43	79
1960-64	24	16
After 1964	3	1
Did not reply	3	15
	119 (36.4%)	208 (63.6%)

Eighty-two of the emigrant doctors made two moves, either emigrating first to the United States and then moving to Canada, or vice versa. As might be expected, the United States was the gainer in this process, receiving (net) twenty-eight full-time and six part-time British doctors from Canada. If this rate of movement applied to *all* medical faculty, Canadian as well as British, it would seem to confirm the "net-loss" estimate of 20 to 30 per cent given earlier.

⁵Dr. T. C. Gibson, "British Physicians on Medical School Faculties in North America", *British Medical Journal*, March 18, 1967, pp. 688-692. Dr. Gibson, an Associate Professor of Medicine at the University of Vermont, compiled a careful list of all doctors with registrable British medical degrees who were on the faculties of American and Canadian medical schools on July 1, 1965. Eventually 865 names were listed, and the total was then reduced to 669 by eliminating those who were American or Canadian by birth, other non-British nationals, temporaries and transients.

The following tabulation shows the length of time the doctors had been qualified before they decided to emigrate to Canada:

On qualification	7
1-5 years	94
6-10 years	103
11-15 years	80
16-20 years	16
More than 20 years	9
Did not reply	18
	<hr/> 327

The London and Scottish medical schools accounted for a large proportion (between a half and two-thirds) of the immigrants. It is clear that promotion blocks in the house officer-registrar-consultant hierarchy of the National Health Service had a good deal to do with the decision to emigrate; but much has been done since the 1950's to overcome these difficulties and to end the frustration, and more will undoubtedly be done if the recommendations of the (British) Royal Commission on Medical Education are implemented.

The following tabulation shows the specialty distribution.

	<i>Full-time</i>	<i>Part-time</i>
Internal medicine	18	27
Surgery	11	40
Psychiatry	11	30
Pathology/bacteriology	15	20
Anaesthetics	9	27
Paediatrics	16	21
Basic sciences	23	3
Radiology	7	23
Preventive medicine	5	8
Obstetrics and gynaecology	4	8
	<hr/> 119	<hr/> 207

The high proportion of part-time to full-time faculty (the reverse of that obtaining in U.S. medical schools) tells us much about the traditional organization of the Canadian medical school. Of equal (and related) interest is the response to questions about the time taken by research, teaching, patient-care, administration and other duties. It was found that 88.8 per cent of full-time faculty but only 46.9 per cent of part-time faculty were engaged in research; whereas teaching duties were listed by 91.1 per cent of full-time faculty and by an about equal proportion (88.5 per cent) of part-time faculty. Patient-care was reported by only 61.2 per cent of full-time faculty but by 86 per cent of the part-timers. "A sign of the times" (as Dr. Gibson puts it) was that 55.6 per cent of full-time

faculty were involved in administration, and even 38.5 per cent of the part-time staff suffered this misfortune.

Finally, and of great importance for Ontario recruitment policy, there are the reasons given for emigration. Apart from promotion blocks (the most important single factor), better economic conditions in North America, improved academic position, advantages for family, and better research facilities ranked high. But, while roughly equal proportions of United States and Canadian immigrants agreed in giving a high ranking to "improved academic position", the percentage of Canadian immigrants giving a high rating to "better research facilities" was much smaller than the percentage of United States immigrants doing so. In other words, the two countries were seen as giving roughly equal opportunities for improving academic position but Canada was not as highly regarded by British doctors in terms of the research facilities offered.⁶ Conversely, "advantages for the family" were seen as greater in Canada than in the United States.

Of some interest in the debate about the effects of medicare is the fact that the emigrants were about equally divided in giving "general dissatisfaction with the National Health Service" as one of their reasons for leaving, but (more important) the dissatisfaction was much higher among the part-time staff (who formed nearly two-thirds of the total immigrant faculty in Canada) than among the full-timers.⁷ Over three-quarters — 77.3 per cent — of the immigrants said they intended to stay in North America permanently, and only 3.3 per cent said categorically that they had no intention of remaining. Over 40 per cent had become citizens of their new country, though the proportion was much higher among the "Americans"; in part, no doubt, because of the full citizenship requirements for licence in many of the states. It is worth noting that 21.6 per cent of those in the United States reported that they had experienced difficulty in complying with the regulations for obtaining a licence, compared with only 5.5 per cent of those in Canada.

The pressure on staff and facilities in Ontario medical schools will be increased even further if there is to be a greatly expanded program of training in the related health professions in the next ten years. Already in some centres (as we saw earlier in this report) approximately half of the teaching in the basic medical science departments is devoted to non-medical students. Moreover, responsibility for clinical training in the specialties is now devolving almost entirely on the medical schools, and the Royal College of Physicians and Surgeons has recommended that, by 1970, residency training should be restricted entirely to hospitals affiliated with a university or other major teaching hospital that offers a full training program in the appropriate specialty.

⁶It might also be argued that this indicates that the type of person attracted to Canada is less interested in research than in teaching and clinical duties. The high proportion of Canadian immigrants employed in a part-time capacity is possibly related to this response.

⁷Specifically, 62.1 per cent of the full-timers said they had *not* been so influenced, compared with 62.6 per cent of the part-timers who said that they had.

The task of finding enough well-qualified teachers and medical scientists has been called "the greatest challenge facing our medical schools today".

Since by 1975, two out of three staff positions in Canadian medical schools will (have to) be occupied by individuals attracted during the period 1967-72, the calibre of staff added during this period will determine in large measure the quality of educational programs through the next decade. This in turn will be reflected in the standard of health care offered to Canadians for a generation. The formidable challenge of acquiring staff over the next few years is therefore a matter of great consequence for Canadian medicine (and a) full scale attack on the problem must be launched by the universities, the profession, and the provincial and federal governments.⁸

To what extent, if any, is the rather alarming picture painted by the spokesmen of interested parties (such as the Canadian Association for the Advancement of the Health Sciences) an exaggeration? A dramatic increase in the number of full-time staff has certainly taken place since 1961-1962 (about 60 per cent in basic sciences and a doubling of clinical full-time faculty); but this has barely kept pace with growing responsibilities. At Queen's, for example, the operating budget and the number of full-time staff have approximately doubled since 1963, and the research budget has increased by more than 50 per cent. The growth in the number of medical students has been relatively small (an increase of only six in the first year at Queen's, for example): the major demand has come from the expansion in residency training and in graduate training in the basic medical sciences, and from the growing pressure for training the related health professions. Experiments with undergraduate and postgraduate curricula and in teaching methods which have been taking place in almost every medical school have added to this. The move away from large formal lectures, the introduction of small-group instruction, and a greater use of electives are three examples only of the change of emphasis in recent years.⁹

Since all these trends are to be encouraged, it would seem that the problem is by no means exaggerated. What is uncertain is to what extent the required build-up in teaching and research manpower can or should come from *new* sources of domestic production and from immigration rather than from a re-

⁸Dr. John Evans, "Future Manpower Needs in Teaching and Research", paper given to the CMA Conference June 1967, mimeo.

⁹David G. Fish, "Medical Manpower in Teaching and Research", paper presented to the CMA Conference June 1967, mimeo. Dr. Fish makes several important relevant points here. 1) Medical faculty is not necessarily the same as medical manpower: over 90 per cent of clinical department staff hold medical degrees, but only 40 per cent of the full-time staff in the basic medical sciences do. 2) The integration of basic science and clinical teaching demands increasing numbers trained in both. 3) As full-time faculty in the clinical fields builds up, it must be expected that the *ratio* between full and part-time faculty will become smaller; but it seems unlikely that this will lead to a significant reduction in the *number* of part-time staff. Indeed, the assumption by medical schools of increasing responsibility for the continuing education of practitioners and pressure for a larger role in patient research for the family doctor are among the factors that suggest otherwise.

allocation of medical manpower¹⁰ from one sector (patient-care) to another (education and research). If the second option were chosen, it would have to be accompanied by greater compensatory use of the health-related professions and a more rational organization of medical practice, a matter to which we return in the next chapter.

The Curriculum

There have been some changes in the medical curricula in the Ontario medical schools over the past few years, but fewer than might have been expected given the pace of change in medicine. At the University of Western Ontario, for example, changes were introduced in 1963 bringing about a reduction in the number of formal teaching hours throughout the four years of the course. One half-day a week was set aside for a study period. Another half-day was designated as an elective period, during which the student could take further studies in depth in subjects in which he was interested. Interdisciplinary conferences were introduced bringing together the basic and clinical science departments in seminars and clinical case presentations. A combined course in neurological sciences was offered in the first two years, combining neuroanatomy, neurophysiology, neurochemistry and neuropharmacology. The number of didactic lectures was reduced in the third and fourth years. At present, the students have one lecture hour daily in their fourth year. The remainder of the time is spent on the wards in the block system of teaching. The fourth year fulfils the requirements of a clinical clerkship.

At Queen's there have been relatively few changes in the time assigned to the various subjects, except for a substantial reduction in the number of hours devoted to anatomy, and a reduction in the amount of time given to pharmacology so as to place more emphasis on clinical therapeutics, which is taught in the third and fourth years. There have been significant changes in teaching methods, however, much greater emphasis being placed on small-group tutorials, seminars, clinics and independent study. There are now no didactic (or formal) lectures in the final year, which is in the form of a clinical clerkship.

At the University of Toronto, there has been a reduction in the number of lectures in the final year and a corresponding increase in the amount of time devoted to clinical studies; courses in neuroanatomy and neurophysiology have been added in the second year; and there has been an increase in the number of lectures in psychiatry and in pharmacology.

The proposals of the medical school at McMaster are of particular interest, both as an indication of the way in which a new school sees its role in medical education on the threshold of the 1970's, and as a debating ground for policy-makers concerned with the establishment of additional schools in Ontario.

¹⁰Or, more accurately (since the shift does not have to be exclusively full-time in terms of bodies), a reallocation of "medical time", to use Dr. Fish's term. According to the recent (CMA) census of Canadian doctors, about 80 per cent of all medical time in Canada is devoted to patient care.

It has been the practice of the medical schools in the province to set a two-year, non-degree medical course as the principal route of entry into the four-year professional training program. While this six-year program has some merit (McMaster argues), it also has serious disadvantages. The student's choice of career is forced in Grade Thirteen; there tends to be conformity in premedical studies; the student tends to be divorced from general university life; and, perhaps most important, the student tends to evaluate courses in the Faculty of Arts and Science in terms of their relevance to a medical career.

McMaster proposes to accept into medicine only those students who have completed a Bachelor degree program at a recognized university, or at least three years of an Honours program in the Faculty of Arts and Science at McMaster. Knowledge of biology and biochemistry will be a requirement for all students seeking entry, but admission into medicine will be governed primarily by the *quality* of undergraduate performance. The majority of students who plan to enter medicine will be likely to stress biological sciences in their undergraduate years, but it is hoped that students will be attracted from other disciplines too, in particular the social sciences.

Thus, students planning a medical career will be advised to pursue an Honours program in biological sciences or social and biological sciences in the Faculty of Arts and Science. At the end of their third year they may elect to complete their degree program in the Faculty of Arts and Science or to enter a medical sciences option under the direction of the Faculty of Medicine, leading to an Honours Bachelor degree.

The medical sciences option will deal specifically with problems of human biology. In conventional medical programs most of this information would be presented in courses of anatomy, physiology and general pathology. The remainder of the program leading to the M.D. degree will consist of a continuous period of approximately eighty weeks of professionally oriented programs in clinical medicine presented primarily in the University Hospital Medical Centre.

It is hoped that the program will attract good students to McMaster; permit diversity of background for students entering the Faculty of Medicine; improve the quality of "premedical" experience; and provide a sound, scientifically based, undifferentiated program in medicine (without prolonging the interval between high school graduation and the M.D.) upon which specialized graduate programs (of which family medicine will be one) can be developed without an intervening junior rotating internship.

In brief, these are the key notions behind the McMaster program: to get away from the traditional "two premedical years, four professional years" pattern; to substitute for it three academic years of general university experience in biological or social sciences followed by three calendar years in medicine; and to stress

“educational experience” (“doing some related things in depth”) rather than the mere acquisition of large numbers of facts (for example, it is intended to bring students *from* the social sciences *into* medicine rather than to feed social science to medical students).

The McMaster program is one response among many to the contemporary challenge. At Nottingham University, the first new medical school in Britain for many years, a three-year course in human biology will be followed by two years of clinical work and two years of preregistration internship. There are many possible variants and some very interesting experiments are under way in the United States. It is probably correct to say that there is less dispute about what should be taught (except that some medical educators are more sceptical than others about the extent to which the behavioural sciences should be tapped) than about the manner in which it should be learned. The “fully integrated” method, a well-known feature of the Western Reserve pattern, is now being followed (to a greater or lesser degree) in a number of other universities (it has been proposed for several in Britain). This is among the more radical of recent innovations: it is also extremely expensive. In such a program (for example) anatomy, physiology, pathology and other appropriate basic sciences bearing on the respiratory tract are studied at the same time as clinical diseases of the chest. Thus a third or fourth year medical student will still be learning basic science subjects, but learning them in contexts which are said to make better sense of them than was possible under the traditional teaching methods.

Sixty years ago, when Flexner made his famous report, there was a gap between the advances that had been made in medical knowledge and what was actually being taught in the medical schools. Today the main gap is between medical teaching and medical practice. As we said in Chapter 1, the crucial questions are how to bridge the gap between discovery and application, how to select what is most important for the newly qualified doctor to know, and how to decide what must (and can safely) be left to postgraduate educational experience.

We have heard evidence to the effect that although medical knowledge has advanced enormously, “what every doctor needs to know” remains the same. Practically every medical witness who has appeared before the Committee on the Healing Arts (whether referring to optometrists, or chiropractors, or dental oral surgeons, or even to other medical specialists) has stressed that it is essential to “understand medicine” before it is possible to make a differential diagnosis, or safely prescribe eyeglasses, or manipulate spines, or perform operations on the jaw, and so on. But what does “understanding medicine” mean? Presumably it means (or should mean) “possessing a basic medical education”. But what is a basic medical education?

The problem is universal: doctors in Britain and the United States are as

much exercised about it as their colleagues in Canada.¹¹ In all the literature the same topics recur: the relation of a basic medical education to modern medical science, to the shortage of doctors, to future trends in medical care; how best to prepare doctors for a lifetime of continuing re-education, and so on. It may be of interest, therefore, to refer to a recent report, *Recommendations as to Basic Medical Education*, published by the U.K. General Medical Council in 1967. These "recommendations" are peculiarly pertinent since the Council (which includes representatives of all the British and Irish universities and the medical qualifying bodies) is, in an important sense, the voice of the British medical Establishment and has the primary responsibility, under the Medical Acts 1858-1958, for supervising medical education in Britain.¹²

Accepting the advice "which it has received, that all doctors, *including general practitioners*, will require in future special and extended vocational training", the Council goes on to say that basic medical education is completed at full registration — i.e., licensing, at the end of the interne year following graduation, as in Ontario.

. . . the Council believes that in medical education there should continue to be a single objective for all doctors up to the time of full registration, whatever their subsequent career. The object of this basic medical education should therefore be to provide doctors with all that is appropriate to the understanding of medicine as an evolving science and art, and to provide a basis for future vocational training; it is not to train doctors to be biochemists, surgeons, general practitioners (sic), or any other kind of specialist.

The Council goes on to say that the necessary understanding of medicine has to be attained through a study of the physical, biological and social sciences, and by the study of man himself in health and disease.

The first fundamental requirement is that basic medical education should give the student knowledge of the sciences upon which medicine depends and an understanding of the scientific method.

Since these, in themselves, cover "a vast range of ascertained knowledge", and the student must "avoid superficiality", his "factual load" must be reduced:

. . . the memorising and reproduction of factual data should not be allowed to interfere with the primary need for fostering the critical study of principles and the development of independent thought.

¹¹In "U.S. Medical School Reforms Praised by Visitor from U.K.", *Medical Tribune*, September 18, 1967, the editors published two juxtaposed photographs. It is to be hoped that the irony was unintentional. The first, over the caption "Curriculum changes for medical students in Great Britain, such as these at Edinburgh University, are said to be slow", showed a group of medical students examining a skeleton. The other, over the caption "Students at Boston University Medical Center benefit from changes in medical education now going on in U.S. schools", showed a group of medical students — examining a skeleton.

¹²In fact, like the College of Physicians and Surgeons of Ontario, it delegates most of this function to the medical schools.

The second fundamental requirement, says the Council,

. . . is that basic medical education should give the student a comprehensive understanding of man in health and in sickness and an intimate acquaintance with his physical and social environment He should see the patient in his home and family and in school and industry. He should learn about the organisation of medicine, the scope of its various specialities, the role of the general practitioner, and the role of the public health services in the promotion of health.

In furtherance of these general principles, the Council recommended that "instruction" in psychology and sociology (and also some methodology) should be included in the basic medical curriculum:

In the Council's view the study of human structure and function should be combined with the study of human behaviour. The Council considers that instruction should be given in those aspects of the behavioural sciences which are relevant to the study of man as an organism adapting to his social and psychological, no less than his physical, environment. Instruction in the biological and sociological bases of human behaviour, normal emotional and intellectual growth, and the principles of learning theory should be included.¹³

Equally, social and preventive medicine should have an important place in the curriculum. Where possible, the epidemiology and the demographic, social and environmental associations of disease should be integrated in the teaching of other clinical subjects. The development of clinical judgement, however, remains the essential basis of medical training, the Council argued, and clinical clerkships are "an indispensable method of clinical teaching". In his clinical training the student should become familiar "with the contribution which professions supplementary to medicine make to the care of patients", and "in addition to systematic instruction and clerkships in hospital, the student should be introduced to the field of general practice A period of attachment to a general practitioner is desirable". General practice attachments were seen as having a number of potential practical advantages: the student would be given an opportunity to study types of illness not normally found in hospital; he would obtain first-hand knowledge of community services for domiciliary care and the promotion of health; and he would be able to "observe general practice as a vocational opportunity for himself".

On the more general "philosophical" question of the future of medical education, the Council reflected an opinion which seems to be gaining almost universal acceptance. This is, that it is no longer possible for anyone to obtain a comprehensive medical education during his medical school years. "Graduation has

¹³Compare Chapter 1, and see F. M. Martin, F. M. McPherson and P. R. Mayo, "A Course in Psychology and Sociology for Medical Students", *The Lancet*, August 19, 1967, for an account of an interesting experiment at Edinburgh University. The case for inclusion of the behavioural sciences in medical education is very cogently argued by Susser and Watson, *op. cit.*

become neither the end of medical education nor the beginning of the end, but rather the end of a beginning." Beyond the stages of premedical studies and basic medical education there lie two further stages. The first and immediate one is vocational training for a particular career in medicine¹⁴ (including specific vocational training for a career in family, or general, practice). The second, continuing education, would begin upon the completion of vocational training and would extend "to retirement or death".

The BMA, in its evidence to the British Royal Commission on Medical Education, agreed with the Council that "medical education must be continuous from school throughout active professional life" and argued that:

The old concept that at graduation and on registration the medical graduate becomes the "safe doctor", ready to practise . . . is no longer tenable The aim must now be to produce at registration the basic graduate who only with further supervised vocational training in the branch of medicine of his choice can acquire the skills necessary for fully independent practice.

The Royal Commission itself, which reported¹⁵ while this study was in the final stages of preparation, has recommended that the existing undergraduate medical curriculum be revamped, to give it a "structure and objects very different from those of the traditional (British) medical curriculum". *The Lancet* commented¹⁶ that its proposals "put into harder terms the thoughts of the General Medical Council" which we have just outlined. In proposing methods, it has clearly borrowed from the United States ideas which are being progressively adopted also in Canadian medical schools. The Report examines at some length the argument for founding medical education on a degree course in human biology. Its own suggestion is to blend human biology and basic science teaching with clinical teaching in such a way as to lead to the award of a degree in medical science at the end of three years and to the M.B. at the end of five. If for any reason the student failed to complete the full medical course, he would then have a qualification (the degree in medical science) which would allow him to follow a career in a related non-medical or paramedical field. The Commission comments that the system of integrated courses "pioneered in the United States" is expensive in staff-time and is difficult to implement in medical schools (such

¹⁴The Council predicted, for Britain, organized courses of specialist training and arrangements for the certification of specialists such as already exist in Canada, and it prophesied the introduction of Vocational Registers restricting the registrant to the practice of a particular branch of medicine. The Royal Commission on Medical Education (see footnote 15) agreed and has recommended that the GMC should become the Vocational Registering authority.

¹⁵Royal Commission on Medical Education (Todd), 1965-1968. *Report*, Cmnd. 3569. HMSO. So far as concerns the *content* of medical education, the British proposals do not appear to constitute a radical advance on Canadian thinking and current aims. On the contrary, the Commission appears to have borrowed heavily from North American experience.

¹⁶*The Lancet*, April 13, 1969, 809f.

as those of Britain or Canada)¹⁷ where there is a heavy dependence on part-time teachers. But it does not exclude the possibility of their being introduced ("the extent and form of integrated teaching must be decided by each medical school"); indeed, it advocates an extension of group teaching and interdepartmental teaching, and calls for a considerable reduction in formal teaching methods.

So far we have been concerned primarily with the content of the undergraduate curriculum; but there is a further question of some importance, that of examinations. It has been said that "he who controls the examinations controls the curriculum", and this (in Canada) has been held especially against the Royal College of Physicians and Surgeons at the postgraduate level.¹⁸ But it applies also, at the undergraduate level, to the medical schools, the Ontario College and the Medical Council of Canada. To be specific (if oversimple), what the examinations test the curriculum must provide: if the examinations test factual knowledge only, then that is what must be taught; if they are designed to judge the candidate's understanding and his capacity for thinking for himself, what is taught, and how, may be radically different.¹⁹

From what has already been said at various points in this report, it is clear that an elaborate (perhaps too elaborate) examination structure exists in Canadian medicine. And it is somewhat alarming to be told that "traditional medical school examinations are 95 per cent recall and 5 per cent generalization" and that "until they were recently modified, the Medical Council of Canada examinations were 75-95 per cent recall".²⁰ The same authors have reported that in oral examinations "the major questions invoke recall in 60 per cent of the cases; the minor questions in 95 per cent". (Much the same, it has been said, was true "until recently" of the Royal College examinations.) There are strong, though not conclusive,²¹ arguments for the wider adoption of multiple-choice examinations; not only for the familiar reasons (the objection, for example, that if an examiner twice marks 100 essay questions, with a three-month interval between markings, his second marks seldom, if ever, approximate his first) but also because they would aid the establishment of evaluative standards for medical school curricula on a national basis. It may be claiming far too much to say that

¹⁷The examples are the author's, not the Royal Commission's.

¹⁸See p. 225.

¹⁹The Royal Commission on Medical Education was sharply critical of the examination system in Britain which had "tended to test the student's capacity to reproduce . . . textbooks . . . rather than his capacity to discriminate". In effect, it called for a major reduction in formal examinations, particularly at the postgraduate level.

²⁰A study by Drs. J. A. L. Gilbert and D. R. Wilson at the University of Alberta.

²¹Not conclusive because, *inter alia*, there is some evidence that MCE's penalize the really bright student who is not satisfied with a rigid choice; that they deprive the student of self-expression; that previous practice improves performance; and the nimbler-witted, but not necessarily sounder, candidate who can "process" the questions quickly has a distinct edge on others. They are also extremely expensive in faculty time to devise—though, of course, very easy to mark (by computer).

"to the degree to which medical education can be evaluated and subjected to precise measurement, to that same degree can quality medical care be brought to our people";²² but there is no doubt that a reappraisal of medical education that ignores the issue of the use, and the purposes, of examinations will be seriously defective.

It is perhaps appropriate to conclude this brief discussion of undergraduate (or basic) medical education with two quotations. The first is from a physician of international repute, Lord Platt, who refers to one of the most important contemporary aspects:

. . . thus we have the paradox that medicine has won its place in the university not through its humanism but through becoming a science, and the influence of the university has been to put it further from and not nearer to the humanities If (medical scientists) regard family doctoring and even consulting practice as comparatively lowly occupations in which the truths of science have not yet come into full blossom, and if they leave the social medicine department to teach students the importance of environment and look upon psychological symptoms either as an inconvenient irrelevance or as a matter for the psychiatrist, then I fear that I am not with them. I am one of those, whom colleagues in other faculties sometimes find difficult to understand (except when they are ill), to whom the practice of medicine is at least as interesting as teaching and research. And the human lessons which medical practice teaches are great and should be passed on to our pupils

. . . we must not forget that in the practice of medicine ethical judgments, about which science has nothing to say, decide upon action to be taken. The pursuit of medicine can never be disinterested My plea . . . is not one against science or against clinical science, or against the exciting years of discovery in which I have been privileged to live, nor is it a plea against introducing research into clinical departments and to the bedside: *it is against a new climate of opinion being built up just as rigid and stereotyped as the old, in which only science, and only one kind of science, is recognised and all other values in medicine are in danger of being lost or are played down in importance* The teachers of medicine are chosen from amongst those who, in deciding for the academic life, have shown more interest in the science than in the art or practice of medicine. Some of the best minds in medicine are to be found amongst them: they have blown a fresh wind which has taken away the cobwebs of medical humbug. *My complaint is only if they profess an attitude towards medical science which though narrow and limited is in danger of dominating the whole of medical teaching*²³

²²Attributed to a former president of the (United States) National Board of Medical Examiners. Many would deny this vehemently—or at least its more obvious implications. Some indeed have suggested that the "evaluation for learning" process (essential for any medical educator within the medical school and the university) should be altogether separated from the process of evaluation for certification and licensing, though how this could be done is far from clear.

²³Sir Robert Platt, *op cit.* Emphasis added. Lord Platt was a member of the Royal Commission on Medical Education, referred to in the text.

The second quotation is from a writer in the *Journal of the American Medical Association*:

The immediate reaction to the "knowledge explosion" is to increase the complexity of the curriculum — to fractionate it, lengthen it, add more and more courses, and make each course more specialized to keep pace with last year's scientific findings. The blind impulse is to keep what we have and simply add more and more to it as new knowledge appears.

This is not a wise course to follow. There are, naturally, weighty social and budgetary considerations which speak against it, but of far greater importance is the fact that this philosophy of medical education — or of any type of education, for that matter — is calculated to produce the learned dunce, the type of pedant who, in the extreme, knows everything and understands nothing. Facts, relations, formulas, techniques are piled up in his head like furniture stored at random in an attic. He is the type of medical man who orders a thousand dollars' worth of the latest and most expensive laboratory tests for his patient and doesn't know what to do with the results when he gets them, since one finding is as important as another. His mental processes lack form, structure, and discrimination and his medical judgments are mechanical and perfunctory.

This is the end result of a "pile it on" philosophy of medical education. In his medical-school days our doctor has been on the receiving end of a series of fragmented courses in which no attempt was made to relate the field in general and conceptual terms to the other areas of knowledge which constitute the vast domain of medical functioning. The supposition was, apparently, that the student would do the integrating. This supposition, however, is eminently unreasonable, since it is extremely unlikely that the average student will achieve an integration which does not exist in the professor's head.

The so-called knowledge explosion has so fragmented knowledge that there is a real danger that the future will produce an ever-increasing number of specialized scientific hacks. It is a general problem but it is more acute in medicine because the foundations of medical knowledge and practice are so comprehensive. The situation is aggravated further by the fact that research has become a sort of fetish and has acquired a status value. It is now considered chic to be "doing research". I hope I am not misunderstood: obviously, all knowledge grows out of research and there can be no valid knowledge without it. I merely wish to make the point that in recent years there is an increasing insidious motivation to do research because of the perquisites which accrue to a large well-heeled research laboratory with ample quarters, elaborate and exquisitely sensitive hardware, and many bodies. The point to be made in this context is that much of advanced instruction consists in reciting and evaluating the products of research programs so conceived. The sound and related point is that many young medical students who otherwise have no genuine research talent or inclination are seduced to "go into research" who would be better advised to prepare adequately for medical practice.²⁴

²⁴J. A. Gengerelli, *Journal of the American Medical Association*, Vol. 193, 1965, p. 583.

Postgraduate Education

Two related issues arise concerning postgraduate education: specialist training in general (the production of specialists) and the future education of the family practitioner (who may well practise a new kind of specialism). The second of these is of crucial importance; not only in itself, but because a decision to establish, on a large scale, specialized vocational training for family practice would have a profound effect on the nature and content of the entire undergraduate medical program. Until very recently at least, the medical schools²⁵ have had two possibly contradictory goals: to lay the groundwork for specialist vocational training leading to a career in one of the recognized specialties, *and* to turn out doctors who, after a year or more of postgraduate rotating (or sometimes "mixed" internship), will be fitted for general practice.

What may perhaps be regarded as the dominant evolving philosophy was well stated in the *Ontario Medical Review* by Dr. Laurence Wilson. Dr. Wilson said he does not believe

. . . that it is the job of the medical school to turn out embryo general practitioners or embryo surgeons or embryo ophthalmologists; rather it seems to me the job of the medical school to teach the student to understand the principles of the pre-clinical and clinical sciences and to continue to teach himself, not only during his graduate training but during his entire professional life.

In the interne and residency program, however, there is every reason to introduce bias appropriate to the professional niche which the young graduate wishes ultimately to fill. And it is in this area that we come on some very contentious issues, especially regarding the training of general practitioners . . . there is likely to be little heat generated by the discussion as to how a urologist should be trained simply because no one has any very major doubts about what a urologist is to do. One's feelings about the training of general practitioners are dependent upon one's concept of what a general practitioner (of the future) is to do . . .²⁶

A detailed discussion of vocational training for the general practitioner may be left on one side for the moment (see p. 233). We should, however, glance briefly at the course of postgraduate education as a whole. At present (aside from a few pilot schemes and the new McMaster experiment in family medicine, which are discussed below), the general physician need have only one year of hospital experience following graduation before practice. The specialist, on the other hand, must take the preregistration internship, and then from four to five years of professional specialist training, depending on the specialty. The British Royal Commission on Medical Education has recommended a radical restructuring of the entire postgraduate experience, and in so doing accepts general or family

²⁵This is true of Britain also.

²⁶Dr. D. L. Wilson, "The Place of Internships and Residencies in Medical Education", Part I, *Ontario Medical Review*, March 1964, p. 195; Part II, *Ontario Medical Review*, April 1964, p. 275.

practice as a "specialty" — or at any rate, as a "vocation" — which requires further training. It agrees with the BMA's contention (contained in its evidence to the Commission and summing up the consensus of medical opinion in Britain today) that: "at the end of his university training the student can only be regarded as a multi-potential embryo doctor who requires further special vocational training to enable him eventually to practise independently in the branch he has chosen". The Commission has recommended:

- 1) An interne year, corresponding broadly to the existing preregistration year (this was made compulsory in Britain in 1953) which is virtually identical to the Ontario preregistration year; followed by
- 2) A period of general professional training lasting about three years, in which the young doctor would be given "systematic and varied experience in the general field wherein he hoped to make his career" (during these years it is envisaged that the doctor would pass through a series of approved posts in teaching and non-teaching hospitals, health centres — a kind of group practice — and general practice, the particular combination being geared to his aptitudes and career intentions); and
- 3) At least two years further training depending on specialty (or "vocation"): either *less* intensive, "merging into the normal responsibilities of a professional career" (presumably chiefly G.P.'s), or *more* intensive and advanced, "to bring the most able hospital doctors more quickly than others to the point where they might reasonably expect to be considered for consultant appointments".

Some form of certification would follow the successful completion of the three general professional years, and a vocational licence (vocational registration) would follow the two or more further years of advanced training. During the latter, the general practitioner in the making would be permitted to practise as an assistant to a principal general practitioner (i.e., one in full practice) and the budding specialist would be given appropriate recognition in the hospital hierarchy.

There is a wide measure of agreement with Dr. Wilson's view that the first ingredient of a successful internship and residency program is that the interne should be protected "to some extent from the hurly-burly of clinical practice" and that he should "be given a controlled workload which allows reasonable time for study and leisure". This has been a source of much trouble, not only in Canada, but in the United States and Britain as well. Too often the interne or resident has been looked on in all these countries as a sort of "workhorse" to be exploited.

Dr. Wilson's second ingredient is that the graduate clinical training years must give the trainee increasing responsibility, under supervision and graded according to his abilities: this can work only if the trainee is left in one service

long enough to be given responsibility with safety (an "insurmountable" defect, he thinks, of the rotating internship). The final ingredient is instruction, and, as Dr. Wilson puts it: "We tend to overemphasize the role of the senior clinician here and to undervalue the mutual instruction which members of the house staff provide for themselves."²⁷ This implies that:

. . . a hospital must maintain a house staff of a certain minimum complexity if its members are to benefit properly from their work. Thus I would state categorically that an internship is not worth its salt unless the interne has associated with him throughout the year, not only a reasonable number of other internes, but also good assistant residents on the services through which he rotates. He will learn more from the assistant resident and from his fellow internes, if they are good men, than he will learn from the best and most conscientious attending staff.²⁸

What is true of the junior interne presumably is true also of the resident. The census taken in April 1965 by Clarke, Fish and Giles²⁹ provided the following distribution of residents in Canada as a whole (there were three non-responding hospitals out of the 151 approved at that date by the Royal College):

TABLE 11
Distribution of Residents in Canadian Hospitals Approved for Residency Training by the Royal College of Physicians and Surgeons of Canada, April 1965

Number of residents per hospital	Number of hospitals		Total number of residents	
	No.	%	No.	%
None	31	20.5	—	—
1-4	38	25.1	74	2.3
5-9	16	10.6	106	3.4
10-19	20	13.2	293	9.3
20-49	22	14.6	706	22.3
50-99	14	9.3	972	30.7
100-199	6	4.0	758	24.0
200 and over	1	0.7	253	8.0
No response	3	2.0	—	—
Total	151	100.0	3,162	100.0

²⁷It must be remembered too that a part of the "houseman's" role (in a teaching hospital) is devoted to the training of medical students—i.e., undergraduates.

²⁸Dr. D. L. Wilson, *op. cit.*

²⁹G. G. Clarke, D. G. Fish, and T. J. Giles, "A Census of Residents in Canadian Hospitals Approved for Training by the Royal College . . . April 1965", *Canadian Medical Association Journal*, Vol. 94, April 9, 1966, p. 777.

Thus, though more than half the hospitals had nine residents or less, over 60 per cent of the residents were in 14 per cent of the hospitals. Putting this slightly differently, forty-three hospitals each having twenty or more residents accounted for 85 per cent of all the residents in Canada (65 per cent were, in fact, in teaching hospitals and seven of these contained one-third of all residents); yet there was a very large number of hospitals with only a few residents each.

TABLE 12

Field of Training and Ultimate Specialty Goal of Residents in Approved Canadian Hospitals, April 1965

Specialty	Residents presently training in specialty		Residents choosing specialty as ultimate goal	
	No.	%	No.	%
Internal medicine	713	22.6	497	15.8
Anaesthesia	251	7.9	301	9.5
Bacteriology	9	0.3	8	0.3
Dermatology	12	0.4	21	0.7
Neurology	53	1.7	60	1.9
Paediatrics	223	7.1	218	6.9
Pathology	279	8.8	150	4.7
Physical medicine and rehabilitation	25	0.8	26	0.8
Psychiatry	352	11.1	357	11.3
Public health	1	0.1	3	0.1
Diagnostic radiology	166	5.2	191	6.0
Therapeutic radiology	26	0.8	25	0.8
General surgery	483	15.4	323	10.2
Cardiovascular and thoracic surgery	35	1.1	44	1.4
Neurosurgery	42	1.3	53	1.7
Obstetrics and gynaecology	140	4.4	183	5.8
Ophthalmology	79	2.5	97	3.1
Orthopaedic surgery	77	2.4	102	3.2
Otolaryngology	61	1.9	79	2.5
Plastic surgery	30	0.9	42	1.3
Urology	61	1.9	90	2.8
Other	39	1.2	32	1.0
General practice	3	0.1	50	1.6
No commitment	2	0.1	51	1.6
No answer	—	—	159	5.0

SOURCE: *Canadian Medical Association Journal*, Vol. 94, April 9, 1966, p. 783.

Table 12, which shows the field of training and ultimate specialty goals of the residents, is of particular interest. The miniscule proportion choosing general practice as their ultimate goal contrasts strikingly with the large proportion opting for internal medicine, paediatrics, and obstetrics and gynaecology. There are some interesting differences (not shown in the table) in the citizenship status of those opting for particular specialties. Whereas, for example, more than three-quarters of those opting for internal medicine were either Canadian citizens or landed immigrants, 47.2 per cent of the potential neurosurgeons and 36 per cent of the potential paediatricians were foreign trainees.

Unfortunately, no comparable figures are available for Ontario alone, but the fact that the province constitutes a very large sample of the whole doctor population suggests that the orders of magnitude cannot be very different.

A recent study of residents' attitudes to their training by D. G. Fish³⁰ provides some valuable data. The survey was confined to graduates of Canadian medical schools training in English-speaking hospitals in Ontario and Quebec, who were beginning their last year of training at the time of interview and were working towards one of the five major specialties. Sixty residents were interviewed in twenty-one hospitals in six different cities.

On the general issue of the Royal College qualifications, most residents viewed the Fellowship as virtually mandatory for a career involving teaching and research in the major hospital centres, and accepted this; but many objected to the need, as they perceived it, for holding a Fellowship in order to qualify for hospital privileges in some of the smaller centres. As Dr. Fish points out:

Whether or not it is true that the Fellowship has become the operative standard for practice and hospital privileges in specialties in our urban centres, the fact that residents believe that this is so has an effect on their training and learning experience and on their career aspirations.³¹

Of the residents interviewed, 80 per cent intended to write their Fellowship examinations; and in addition to the 20 per cent who expressed an intention to proceed to a full-time academic career, another 50 per cent said they hoped to be able to obtain a part-time academic appointment in conjunction with their private practice. It would seem that they now regard private practice with a part-time teaching appointment as the modal form of practice in a university-affiliated hospital. Dr. Fish's comment is that:

In the same way that medical schools are criticized for their pattern of education which leads students into specialization rather than general practice, it might be wondered whether specialty training in the large teaching hospitals does not produce academic specialists rather than specialists oriented towards community practice.

³⁰D. G. Fish, "The Resident's View of Residency Training in Canada", *Canadian Medical Association Journal*, Vol. 94, April 9, 1966, p. 800.

³¹*Ibid.*

In attempting to ascertain the factors that influenced (the choice of hospital) it became apparent that most of the residents had found themselves the victims of a system . . . rather than free agents . . .³²

The "system" seems to vary from specialty to specialty and according to the university-centre concerned: residents in closely-controlled university programs complained of the lack of freedom of choice (of hospitals and staff men to work under), while those in centres (or specialties) where the hospital set the policy complained of a lack of security and "the tension created by the knowledge that you are always under the threat of being chopped". Those residents under neither system were even more worried, complaining of a complete lack of direction: "Each year you must make a choice of where to go. This is left up to you."

There was a good deal of worry about examinations. Some complained of a lack of time to study for the "theoretical" requirements of the examinations ("If you had to depend on your hospital experience alone you would never get through"); others resented the high "theoretical" content and wanted the examinations to test "experience" and clinical ability more than they did. Dr. Fish continues:

The emphasis that the residents placed on the examination in the interviews is not surprising, in view of the imminence of their examinations. Nonetheless, the folklore . . . as described by these residents merits some attention. Very few regarded the examinations as unduly difficult but sought instead a variety of reasons for the high failure rate.

(i) Restrictive policies on the part of the Royal College aim at keeping a balance between the need for practitioners in a particular specialty and the number of candidates permitted to pass.

(ii) The Royal College operates as a "closed shop" or "private club", factors other than academic excellence or clinical ability governing admission.

(iii) An element of chance enters into the selection of examination topics. The operation of chance was illustrated by a couple of residents who mentioned hearing of persons who had failed the Certification examination but passed the Fellowship.

(iv) The personal biases and opinions of examiners are significant. Some told stories of candidates who claimed to have failed because of conflict with the examiner's opinion on a debatable subject.

(v) Examiners try to fail candidates. They look for isolated gaps in the residents' knowledge rather than seeking a broad evaluation of how much they know.

Some residents, of course, recognized that the high failure rate could be due to lack of proper qualifications on the part of the candidate, especially those residents from foreign countries. Residents in several of the larger teaching hospitals believed that the failure rate for these centres was low and concluded that the training is not adequate in other centres. This more rational approach was not characteristic, however, and the interviews were replete with anecdotes about apparently well-qualified candidates who had failed.

³²*Ibid.*

In any event, the fact that an examination "folklore" should have arisen is not surprising in view of the anxiety and uncertainty generated by such an important stage of a doctor's career. It may be regarded as unfortunate, however, that the image which residents have of the Royal College is dominated by a picture of examinations that are regarded as having little relation to the apparent goals of the training, which demand nebulous and uncertain standards of achievement and permit a high degree of subjectivity to enter into the evaluation.³³

Dr. Fish emphasizes the point that the locus of dissatisfaction (as expressed in the interviews) "lay in the examinations, not in the training itself".³⁴ Criticism from sources other than the residents, however, tends to focus on *the diffusion of responsibility for training*. It is an odd situation, from the standpoint of public policy, that the institutions responsible for providing the postgraduate medical education (the hospitals and the medical schools) are provincial institutions, whereas the body responsible for examining and for making major policy decisions affecting the future development of the specialties operates at the federal level.³⁵ The graduates in training (the residents) can scarcely be blamed if they feel they are caught in the middle of this diffused system.

General Practice vs. Specialization

An emerging approach to the problem of the future of general practice (one that has been called by its critics "a mere act of faith") is implicit in the aims of the College of Family Physicians. Fundamentally, says the College, it is

... charged with accomplishing for the general practitioner through education what the Royal College of Physicians and Surgeons of Canada is accomplishing for those practitioners specializing in a restricted (sic) field of medicine and surgery. The College's work is predicated on two beliefs: first, that general practice is itself an important entity and not merely the absence of a specialty; and second, that it must be accepted that the physician who elects to cover the broadest spectrum of services can no longer be satisfied with a minimum amount of training.

Part at least of the blame for the plight of the general practitioner is laid at the door of educational and research institutions, particularly the medical schools. Among the complaints are a scarcity of training programs in general or family practice; lack of interest in the continuing education of the G.P.;

³³*Ibid.*

³⁴An extensive correspondence on the subject of the Royal College and its examinations appeared in the *Canadian Medical Association Journal* during 1967. The recent Royal Commission in Quebec (the Castanguay Commission) was extremely critical of resident training in the province, finding it "primitive" and "fifty years behind the times". The Commission commented that people who spent eighty to 100 hours a week on the job could hardly do serious study as well, and thought that residents were underpaid (pay was then slightly lower in Ontario). It will be remembered that there was a "sit-in" of Quebec residents in January 1967.

³⁵If we add the specialty associations (as we should) we have a third set of institutions, in this case operating partly at the federal and partly at the provincial level.

prejudice in favour of the specialties (shown, for instance, in the failure of medical schools to provide for G.P. representation on their governing bodies);³⁶ the shortage of general practice residencies; and exclusion of the G.P. from the teaching hospitals. It is argued that the student socialization process is now almost wholly oriented towards the specialties because academic medicine has largely abandoned its interest in "the art of patient care"; because illness is now treated as a thing in itself and not as one of a multiplicity of conditions of a whole person, the patient; because research is the prime consideration in the selection and promotion of medical school teachers (who are selected from among the brightest and best medical students — "to the detriment of the actual practice of medicine"); and because the "scientific" approach to patient care has reduced personal contact between patient and doctor to a minimum. Some critics have even suggested that research should be completely divorced from the medical schools and concentrated in associated research institutes "so that the values and assumptions of the one will not interfere with (those of) the other".³⁷

Blame is also put upon the unplanned and uncoordinated growth of medical practice (see Chapter 13). We noted earlier that nearly 30 per cent of Dr. Fish's sample of residents in Ontario and Quebec had decided to specialize in internal medicine, paediatrics, or obstetrics and gynaecology on completion of their training (nearly 40 per cent if one includes as well those opting for general surgery).³⁸ These are the specialisms from which are drawn the largest proportion of those qualified specialists (nearly 15 per cent of all specialists, according to a recent CMA survey) who go on to provide a "near" or "limited" general practice.

In other words, the blurred margin between the specialist and the general practitioner is wide: at least in the more traditional specialties of internal medicine, paediatrics, obstetrics and gynaecology, and even general surgery. But it must nevertheless be asked whether "limited" general practice is really general practice at all — or perhaps, more specifically, how "limited" it can be before it ceases to be general practice. It is difficult to escape the conclusion that if the modal general practitioner of the future is to be a limited general practitioner³⁹

³⁶And medical student selection committees (it is suggested that selection committees tend to select in their own image).

³⁷Quoted in R. H. Lent and Rose Scott, "Knowledge, Numbers and Values: Medical Education Since 1950", *Canadian Medical Association Journal*, Vol. 97, December 2, 1967, pp. 1418-1427.

³⁸At the preresidency stage, however, the doctors' attitudes look a little different. Fish and Mount found, in one study, that 55.6 per cent of fourth year medical students had made up their minds what they were going to do when they finished medical school — 22.5 per cent of these had selected general practice, whereas 8.5 per cent had selected internal medicine and 4.3 per cent paediatrics. (Unpublished study for AMCC.) This may imply that some change their minds during their interne years. Supporters of the College suggest that this is due to a lack of graduate programs in family medicine.

³⁹Limited, that is, to certain aspects of general practice such as paediatrics.

(as some people would like him to be), then the "truly" general practitioner is bound to be just an inferior doctor who is incapable of specializing in anything.

This would be an insane situation. It is certain, of course, that the general practitioner can no longer practise (and, indeed, for years has been unable to practise) a full range of medicine. Is there not, however, an entirely new role for him as family physician, treating the whole patient, providing "community care"? The notion is dismissed by some medical critics as illusory; but it is significant that very few patients seem to share this view. (This is a matter on which we commented in Chapter 1, drawing attention to the findings of the Hill-Wilson study in Hamilton.) The patient may be pardoned if he doubts the wisdom of a trend that sees no virtue in the generalist, just as he may be permitted to be sceptical about the argument that the specialist, "who after all has gone through the same basic training, including a common internship, as the general practitioner", is fully capable of advising and treating the patient, even though the patient's complaint is not one that his specialty allows him to treat.⁴⁰

One thing is certain: that indecision about the role of the general practitioner cannot be allowed to continue indefinitely without lasting damage to the practice of medicine. In this respect it is useful to refer again to the work of Ann Cartwright.⁴¹ Though she was writing of British experience, it is evident that this is much closer to Canadian problems than is sometimes realized, notwithstanding substantial differences in the manner in which medicine is organized and paid for in the two countries.

Miss Cartwright writes that the lack of job definition bedevils the relationship between general practice and hospital, hinders effective collaboration with public health and other community services, and adversely affects the relationship between patients and doctors.

Hospitals do not know what to expect of general practitioners. They resent it when . . . doctors refer patients (to outpatient clinics, emergency departments) for procedures they feel the doctors could undertake themselves. On other occasions hospitals retain patients unnecessarily, uncertain whether the general practitioner is prepared to accept responsibility Some important facets of medical care are neglected because no one accepts responsibility for them. Changing patterns of disease and develop-

⁴⁰"Without arguing that it is necessarily all to the good when a patient takes her dermatitis directly to a dermatologist . . . are we sure that it is totally bad? Does anyone seriously believe that advanced training somehow unfits a man for general practice?" (Dr. Laurence Wilson, *Ontario Medical Review*, April 1964, p. 276.) The answer is "yes—the many patients who have fallen into the hands of the wrong specialist by mistake". On the other side of the coin, there is evidence that many first-contact specialists are unhappy about *their* role: for example, 46 per cent of first-contact paediatricians surveyed by W. N. Jeffers (*Medical Economics*, Vol. 43, October 3, 1966, p. 158). A survey of paediatricians reported about the same time (*Paediatrics*, Vol. 38, August 1966, p. 264) showed that half their time was spent in well-baby care, and 22 per cent in dealing with common respiratory conditions: a clear waste of specialist training and manpower.

⁴¹Ann Cartwright, *op. cit.*

ments in medical science are making a medical service based simply on overt medical need obsolete and inefficient, yet general practitioners give little or no preventive care to their adult patients, and what service there is from other sources is haphazard and generally uncoordinated

Patients do not make the best use of the service when they are uncertain about its potentialities

Some general practitioners feel insecure because they are uncertain what is expected of them; others are resentful because they regard their job as inappropriate.⁴²

The College of Family Physicians has denied that it has the final answer to the question "how best to train the family physician of the future".⁴³ At the same time, however, it defends the experiments that it is presently sponsoring in medical education. Its detractors argue that the College is embarking on new programs before a need has been clearly demonstrated and before the future role of the family doctor has been properly evaluated. There is some merit in these charges, but probably not enough to warrant postponing action even further.⁴⁴ Some of these experiments relate to undergraduate medical education, some to postgraduate training, and some to continuing education. The last of these can be conveniently deferred until the final section of this chapter; the first and second are most appropriately considered together here.

One prong of the College's two-pronged attack on the educational problem of raising the professional status of the family doctor is an attempt to inject more experience of the problems and potentialities of general practice into the undergraduate medical program. The other is to press for graduate training programs in general practice after completion of a basic medical education. The implication of both lines of advance is that there must be more and better-qualified *teachers* of family medicine in the medical schools and teaching hospitals.

⁴²*Ibid*, p. 218.

⁴³See, for example, "Dr. Donald Rice Comments on Answers Before Questions", *The Medical Post*, November 21, 1967.

⁴⁴There is now much evidence from studies made in Canada, the United States, and Britain to support the efforts that are currently under way in this country. We saw above that most influential opinion in Britain now accepts the concept of family medicine and of specialized vocational training for it. The Millis Commission in the United States made the following recommendations with respect to medical education for family practice at the graduate level:

Teaching should stress "continuing and comprehensive patient responsibility" rather than the episodic handling of acute conditions in the several areas of specialization.

Experience in the handling of emergency cases and knowledge of the specialized care required before and following surgery should be included.

There should be taught a new body of knowledge (family practice) in addition to the medical specialties.

The level of training should be on a par with other specialties. A two-year graduate program is insufficient.

One of the College's early experiments, the preceptorship scheme — which involved placing medical students for short periods with general practitioners — has not been a great success,⁴⁵ at least in Ontario. The medical schools have been, on the whole, hostile, not trusting the general practitioners to give adequate training. The response from general practitioners to act as preceptors has been only fair, but even so, there have been many more preceptors than preceptees. Toronto and Queen's medical schools do make use of the scheme for a few weeks in the summer (Queen's students get about four days with a G.P.).

The next step taken by the College's Committee on Advanced Training was to sponsor two pilot projects, one in Calgary (at the Calgary General Hospital) in liaison with the University of Alberta (now the University of Calgary⁴⁶); the other in London, Ontario (at St. Joseph's Hospital) in liaison with the University of Western Ontario. The OMA was associated with the planning of these. The programs began in the summer of 1966. A third project (which we shall consider more fully in a moment) has now started in association with the new medical school at McMaster University, in the Henderson General Hospital in Hamilton. The College had less (directly) to do with this; but it has given it its blessing. The College's notion is that all programs of this kind should lead to a Certificate in Family Medicine which would be on a par with the specialist certification offered by the Royal College. The Royal College has been cautious and members of the College of Family Physicians to whom we talked accused it of "dragging its feet".

The Calgary project, directed by Dr. John Corley, a former president of the Alberta Chapter of the College of Family Physicians, had an initial intake of twelve students drawn from the four Western universities, and the project was aided by a three-year promise of financial assistance from provincial governments. In mid-1968 Dr. Corley reported that the program had been running into difficulties. There had been "a high and discouraging drop-out rate", and certain staff morale problems had arisen, because the aims of the program were not sufficiently clearly defined at the outset.⁴⁷ Dr. Humber, the Director of the London school (which has also run into problems), is a former President of the Ontario Chapter of the College.

The McMaster program started in July 1967. This is a three-year course intended to train the young graduate for family practice. The first year is approved by the CMA as a junior internship and fulfils the requirements of the College of Physicians and Surgeons of Ontario. A graduate of any recognized medical

⁴⁵Preceptorships are used in a number of countries — for example, in Australia. Some doctors feel that this is a more realistic way of training a family physician than in a Department of General Practice of a hospital. (See, for example, "The General Practitioner as Teacher", *Journal of the College of General Practice*, March 1967, pp. 61-62.)

⁴⁶Since the Calgary campus became a separate entity.

⁴⁷*Toronto Globe and Mail*, May 15, 1968.

school in Canada or abroad may apply for enrolment, and "applicants will be considered for one or more of the three years". In planning the content and shape of the course "eight experienced family doctors . . . examined their own activities" and discussions were held with "consultants in surgery, paediatrics, obstetrics and gynaecology, psychiatry, and medicine concerning aspects (of those specialties) which relate to and are part of Family Medicine"⁴⁸ The course is offered by the McMaster Family Practice Unit. The students work in the McMaster University Clinic, located in a wing of the Henderson General Hospital, and in the two Hamilton Civic Hospitals and St. Joseph's Hospital. Unmarried trainees live in the internes' quarters while on rotation in these hospitals. Part of the purpose of the Unit is to conduct research on the quality of the medical care provided, the content of family practice, and the major clinical problems encountered. This will be carried out by staff, graduate students and a full-time health research analyst.

The program includes both formal in-hospital training and exposure to family practice in the clinic. Four Hamilton physicians have relocated their practices in the clinic, and, as such, have become full-time members of the Department of Family Medicine in the University. Two of these doctors have been in practice for six years and two for ten years. The students are paid OHSC interne and assistant resident rates while in training, and there are various fringe benefits.⁴⁹

The curriculum (which is experimental)⁵⁰ includes, at present: a period of four months in the Family Practice Unit and two months each in paediatrics, medicine, obstetrics and gynaecology, and surgery and emergency in the first and second years; and six months in the Family Practice Unit and two months in each of medicine, research and an option in the third and final year.

Throughout the program the graduate student is personally involved in the continuing medical care of families. The role and function of community paramedical services as well as the economics, office management, and ethics of medical practice are stressed. Seminars, journal reviews and ward rounds form an important part of the program.

An average day in the Family Practice Unit would be as follows. The student would meet the doctor to whom he had been assigned at eight a.m. He would do hospital rounds with him and then accompany the doctor on house calls,

⁴⁸Information and quotations in what follows are drawn from McMaster publications, personal interviews and correspondence with Dr. R. G. McCauley, the Director, and an article by Dr. McCauley in the *Canadian Medical Association Journal*, Vol. 96, April 8, 1967, pp. 1036-1039. Other information in this section is based on extensive interviews and correspondence with members of the College and local G.P.'s in various towns of the province.

⁴⁹All become members of the Canadian Medical Protective Association while in training, the fee being paid by the Hamilton Civic Hospitals; all are placed on the Educational Register, the fee again being paid by the hospitals.

⁵⁰It was planned by the Dean and Assistant Dean of the Medical School and the four G.P.'s aided by an advisory committee of seven, all members of the College of Family Physicians.

standing by, but having things explained to him. After lunch, patients would be seen in the clinic (the doctor's "office" hours) until five p.m. Here the student would be introduced to patients and would make the diagnoses and prescribe treatment, the doctor in charge following up and either agreeing or altering them. The student would also go out with the doctor when he was on call at night.

The initial intake to the McMaster course consisted of eight students selected by the department with the help of an Advisory Committee of local G.P.'s: three had just left medical school, four had finished their preregistration interne year, and one (classed as a Fellow) had a certificate in internal medicine.

The form of certificate to be issued to the class on completion of the course had not been decided at the time we concluded our inquiries. This would seem to be a major stumbling-block: until there is some formal (and relatively prestigious) recognition of the value of graduate training for family practice, students are bound to be sceptical of its practical career value. There are significant differences in the content of the Calgary, London and Hamilton programs; and, as further experiments are made, further differences will undoubtedly appear. The establishment of a recognized postgraduate qualification in family medicine is, therefore, a matter of some urgency if these early experiments are to lead to positive progress.⁵¹ At present, however, there is little agreement as to who should award it: the university, the Royal College or the College of Family Physicians.

We were told that an immense advantage that has accrued to the McMaster program is the fact that it was begun when the medical school was itself in the planning stage. The College of Family Physicians, as such, has not been directly concerned, but the local Academy of Medicine has; and the Dean of the Medical School has been favourably disposed from the start towards what the local G.P.'s want to do. Essentially the scheme has been devised by G.P.'s for G.P.'s, with university blessing. The G.P.'s in Hamilton are well placed for hospital privileges and referrals, and they have had (it is claimed) "the first real opportunity to devise a course that is not research-centred or disease-centred, that will prepare the G.P. for the type of case he will actually meet and not show him the one-patient-in-a-hundred who comes into the teaching hospitals, that will provide a personal interest in people and not just their diseased parts". At the moment, it is contended, the patient the medical student sees is most likely to be the sort of case that needs specialist treatment, hardly ever the one the G.P. will see in his office or in the patient's home — for example, pneumonias, acute infections like hepatitis, gall bladder infections, measles, infant convulsions. It is hardly surprising, our informants argue, that the typical medical student is not

⁵¹Some members of the College, however, believe that talk of certification is "premature" (personal information). But we have heard it argued that no doctor should be licensed to practise as a family physician unless he has completed at least two years of work for a Certificate in Family Medicine.

interested in family practice, since he is taught by specialists and never sees a G.P. until the end of his training. The result is that the man who goes into general practice is regarded by his contemporaries, fairly or unfairly, as a man who is not capable of specialization.⁵²

The College continues to exert pressure on medical schools and teaching hospitals to establish family practice teaching in Departments of General Practice. This is now done in a number of the Toronto hospitals, for example, and a Family Care Unit was set up at Kingston General Hospital in September 1967. This unit was intended to provide residents, internes and senior undergraduates with instruction in family medicine as well as contribute to the training of internists and paediatricians, the patients being drawn from the practices of local doctors. It is perhaps not without significance, however, that the doctor originally appointed to direct the unit was an internist, and he was assisted by a paediatrician.

The educational philosophy of the College of Family Physicians is stated broadly in its Manual on Training in Family Medicine, prepared by its Committee on Advanced Training. The following is a digest of the major premises.

- 1) The College believes that, if health care of high quality is to be readily available to the Canadian people, a corps of family physicians must be trained to provide a major part of it, though it acknowledges that the ideal method for training the family physician is not yet fully known.
- 2) Though there are wide differences of opinion concerning the best method of providing comprehensive medical care, the College has concluded that family medical care can best be given by a physician specifically trained for this task. It defines a family physician as one who is trained to provide primary, continuing, comprehensive medical care to any or all members of the family, using all the available ancillary and consulting services. Family medicine is defined as that body of medical knowledge that relates to the continuing health maintenance of the family — the basic social unit.
- 3) The College believes that to meet medical needs of the family specific training that will achieve these ends must be given in an academic setting.
- 4) The following considerations should guide the development of pilot projects:
 - (a) The standards which will prevail in family practice residencies should in every way meet the standards set for other specialty training.
 - (b) If family medicine is to be taught as a specific entity, its present and projected content has to be more accurately defined.

⁵²Some new general practitioners are men who have failed their specialty examinations: for there is no system of preselection.

(c) Initially, teaching facilities traditionally used in medical education should be used in training for family medicine. Community hospitals, group practices and other aggregations, not presently used, should also be employed. The hospital-based, family practice teaching unit should be a major facility in such training.

(d) The family practice trainee should receive his instruction from specialists representing the various disciplines contributing to family medicine, and also from selected family physicians.

5) The best of today's general practitioners have, and the trained family physician will have, certain special characteristics: a sound general knowledge of all clinical disciplines, and a training in *breadth* that qualifies him to provide comprehensive medical care. The *depth* of his training in specific disciplines has varied and will continue to vary, depending upon his personal aptitudes and interests. His special competence, however, is in the area known as psychosocial medicine.

6) Because of his training and his concentration on the family and its individual members, the family physician will:

(a) *Base his response to the patient on an assessment of (the patient's) total environment.* He will be conscious at all times that behind the symptom or complaint lies a personality, behind the personality a family or other system of interpersonal relationships, and behind all these a community.

(b) *Have an accurate knowledge of community resources* so that, in addition to his own skill, knowledge and personality, he can select from the multiple resources of the community others that will serve the patient.

(c) *Make a precise estimate of the patient's needs*, deciding how complex a service is required; that is, to what degree the total environmental approach is appropriate.

(d) *Provide optimal medical care to large numbers of patients.* In order to do this, he must organize his practice efficiently and use his major resource, his time, effectively. This calls for careful planning, conscientious training of his nurses and other auxiliary staff, and wise use of consultants and members of the other health professions.

7) The College believes that all medical students should have a similar undergraduate education. During his training, each student should have genuine experience in a family practice teaching unit ("model family practice") comparable to his exposure in other major clinical departments. In these units he should participate in the care of the ambulatory patient and thus gain experience in the bulk of community health problems.

8) In order to provide such education to the undergraduate student, the family practice teaching unit should enjoy the same degree of autonomy as other major departments. To administer these units, the College favours a separate department of family medicine in which selected family physicians will contribute to the education of each medical student.

9) As far as possible, family practice units should serve typical cross-sections of the community. Patterns of practice in such units should not be allowed to become artificial; this may happen, for example, if they rely solely on the student health service or other special groups for their experience.

10) The units should demonstrate positive methods of creating and maintaining community health, the preventive aspects of medical care, the natural history of disease, disease detection, health education and social rehabilitation. Public health nurses, social workers, dietitians, marriage counsellors and students of related disciplines should participate in these programs during their training. By providing an opportunity for medical students and those of related health sciences to work together, family practice units can integrate paramedical services into total health care.

11) Such units should be related both to the medical school and to the university teaching hospitals. Only then will it be apparent to medical students that the medical school has made a commitment to the family physician as the principal provider of primary and continuing health care. Family practice units must be more than expanded outpatient departments. In the location or physical arrangements of these departments care must be taken to avoid creating an artificial environment.

12) Family practice units should be research oriented. Research in and into family practice should be stressed. These units should investigate educational methods, patient care, the demand for and availability of medical services, the role of each member of the health care team, and methods of integrating paramedical services.

13) For the successful demonstration of the principles of comprehensive and of continuing medical care to students, family physician teachers should have admitting privileges in the related university hospital, arranged within each department on the basis of the individual physician's experience, interest and demonstrated ability.

14) In time, all family practice units should be expanded to provide both undergraduate and graduate training in family medicine.

15) Despite future changes in family practice, the family physician will still be called upon to provide care to large numbers of patients each day. In view of this fact, a consuming interest in internal medicine, for example, must be tempered by the necessity of rapid handling of a wide variety of situations. In many instances

the family practitioner will not be able to conduct a detailed investigation of an obscure disorder. He must know when and to whom to refer this patient for more extensive investigation.

16) Family medicine is an academic discipline and a clinical entity. It embraces a wide range of diagnostic and therapeutic skills, while leaving to the various specialties the more complex technical problems and procedures. It occupies a unique area because it is concerned with the earliest alterations from normal health and the factors that influence or provoke such alterations. The most important functions of a family physician are recognizing the appropriate management of a given medical problem; interpreting this management in terms that the community, the family and the patient can understand; and facilitating acceptance of the recommendations made by all members of the health team. It is this coordinated service that has often been neglected in fragmented or departmentalized medical practice.

17) The resident in family medicine should gain an understanding of emotional illness in a number of settings. At least part of his training should be taken in a psychiatric teaching unit. He should have early and continuous exposure to psychiatry because, if he becomes familiar with psychiatric terminology, methodology and therapy from the outset, he can contribute more effectively to the varied problems he encounters. However, if his only contact with psychiatry is in a hospital, the resident will lose a great deal. For this reason, his training must be carried forward into his outpatient or home-care experience.

18) The increasing importance of alcoholism and other addictions in present society and the devastating effect of these on the family structure makes it imperative that the family physician have thorough knowledge of the predisposing factors and modern management of these conditions.

19) Health maintenance, organized and provided through the family, is the principal objective of the family physician. For this reason, the resident in family medicine will need specific knowledge of epidemiology, immunology, immunization programs and preventive medicine, and a thorough familiarity with the services provided by the allied health professions.

20) Family medicine, because it is concerned with the provision of total health care, recognizes and eventually will gain much from the behavioural sciences. Studies by social scientists are doing much to enlarge our understanding of the total significance of family medicine. Teaching programs therefore should take advantage of knowledge gained from research in these fields.

From the standpoint of the consumer — the public and the patient — these objectives seem unexceptionable: provided one accepts the major premise that there is a place for the family physician in the future pattern of health care. The alternative (which finds favour with some who are concerned about the doctor

shortage) is that the downgrading of general practice should be accelerated. First contact care would then become a matter for *less* medical training given to *less*-qualified entrants to the profession — i.e., the notion of a “second grade” physician should be accepted. In view of the widely recognized failings of existing first contact care (where so much remains to be done⁵³), this would appear to be a sadly retrograde step.

The proposals of the College square, moreover, with those of the American Medical Association’s Citizens Commission on Graduate Medical Education (the Millis Commission) and, since the United States is unique in the Western world in the extent to which it has downgraded the general practitioner, the views of this body assume particular significance at this time. The Commission urged that comprehensive care should be the chief responsibility of teams of family or primary physicians, trained in psychiatry, internal medicine, paediatrics, preventive medicine and the behavioural sciences, such training to “integrate all the relevant disciplines into an educational experience that (would) involve clinical and research responsibility and status comparable to that enjoyed in other specialty fields”. The Commission further recommended that these programs be of such quality that they would lead to certification by an appropriate specialty body. Granted these assumptions, it would seem to matter little to the general public whether this new style physician is an “upgraded general practitioner” or a refurbished specialist in medicine.⁵⁴

Continuing Education

Medical students tell the story of the professor who held up a respected medical textbook and said: “Half of this is nonsense; unfortunately, I don’t know which half.” Apocryphal though it is, the story underlines one of the more pressing of today’s educational problems. If, as is claimed, the half-life of medical knowledge is now about ten years,⁵⁵ the problem of continuing education takes on a dual aspect: there is the problem of *unlearning* (not merely consciously forgetting) obsolete, and sometimes dangerous knowledge; and there is the problem of keeping up to date with new knowledge. The professional associations and the specialist societies have long contributed to the continuing education of the

⁵³For example, in the recognition and treatment of emotional disorders of children, perceptual and learning handicaps, mental disorders; in preventive medicine; in psychosomatic medicine and the problems of stress.

⁵⁴The distinction is made in an excellent summary of the College’s proposals by Joan Hollobon, “The Way of a G.P. — like a Dodo?”, *Toronto Globe and Mail*, December 25, 1967. Support for the idea that family medicine is a specialty in its own right is now forthcoming in most Western countries. In Britain it has received the blessing of the Nuffield Provincial Hospitals Trust, the BMA and (most recently) the Royal Commission, as well as the College of General Practitioners and a good deal of lay public opinion.

⁵⁵The Millis Commission puts it at five.

doctor by means of scientific conferences and the publication of medical papers and journals.⁵⁶ The nub of the problem is the general practitioner.

Continuing education was originally the primary purpose of the College of Family Physicians, and it remains important today. Both at national and provincial levels, the College cooperates with university Departments of Continuing Education, the hospitals, the OMA and CMA in providing "clinical days" at the hospitals and short courses (of two or three days) for family doctors. And, of course, membership in the College is predicated on the doctor's compliance with the "100 hours rule". Inevitably, however, this is interpreted liberally; and, provided the member takes the trouble to attend the annual conventions and does a minimum amount of private study, he has little difficulty in complying with it.⁵⁷ About half of the 100 hours can be made up from attendance at the annual scientific assembly of the College or of the Provincial Chapter, or the CMA or OMA, clinical days, refresher courses run by the universities, and so on; the balance can be made up by publications, the presentation of a paper at a scientific conference, correspondence courses, borrowing medical tape-recordings, "planned reading", teaching medical students, membership in a family care program in a Department of General Practice, and so on. The College has a limited amount of money available for the organization of hospital clinical days, for postgraduate awards for attendance at short refresher courses, and for further hospital training.

Basically, however, the decision to keep himself up to date rests with the individual practitioner. He keeps his own records, and one official of the College to whom we talked said that the members of the Credentials Committee, who have the job of assessing his program, are lenient. "The chaps are trying."⁵⁸ There is, and can be, no compulsion, and those who try are doing so in order to increase their knowledge and status. Moreover, the doctor will almost certainly be out of pocket when he attends refresher courses. Course fees are an allowable tax expense, but the costs of attending and the losses from the practice are not. On

⁵⁶The Royal College of Physicians and Surgeons, for example, "holds annual scientific meetings; there are regional scientific meetings; and the College maintains an annual visiting professorship and a group of travel fellowships for educational purposes. The funds for a large part of the program of continuing medical education are provided through voluntary donations from Fellows."

The OMA "has been active in this area continuously for forty-five years. The basis has been the provision, at Association expense, of clinical speakers for meetings of Branch Societies, District Associations, Section meetings and the annual meeting of the Association Three days of clinical program are provided at the Annual meeting of the Association. This includes general sessions and concurrent meetings of the Sections" (Evidence to Committee on the Healing Arts.) The OMA contributes about \$15,000 a year to Departments of Continuing Education in the medical schools.

⁵⁷Yet, some still fail to do so.

⁵⁸"We know that it is doubtful that some doctors satisfy the requirement, but the chaps are trying, it is a start. The College has got to provide the leadership in the educational field. You can tear it apart, but there is no other group to take its place." (Interview with one of our research assistants.)

the other hand, *all* expenses incurred in attending a medical convention are allowable. All the doctors we talked to stressed this anomaly in the tax regulations.

It was stated also in evidence (to the Committee on the Healing Arts) that the universities lack the funds and the facilities to offer continuing education on a large scale. The Continuing Education Division at Toronto, for example, is a Division of the Faculty of Medicine and not of the School of Graduate Studies, and hence depends for its funds on the medical school.

It has been suggested by more than one authority that the role of continuing medical education needs to be more clearly defined. According to the OMA:

At the present time there is no lack of opportunity for physicians to advance their scientific knowledge. In addition to the programs mentioned above, the Canadian Medical Association, the College of General Practice of Canada, the Royal College of Physicians and Surgeons of Canada, hospital medical staffs, voluntary health associations, pharmaceutical companies and others, provide outstanding scientific sessions throughout the year. Moreover, doctors have access to many scientific journals which are a good source of information regarding the advances in scientific knowledge and their application in practice.⁵⁹

All this is true: there is a lot going on, but it is piecemeal, inchoate and generally lacking in purposive direction. Says Dr. Laurence Wilson:

I would suggest to you that the day has come when even the most elaborate *graduate* training will give us a practitioner with only the most evanescent competence, unless his training continues year after year. Here is the role of Continuing Education. And I am thinking now not of occasional lectures attended in a drowsy, after-dinner atmosphere of a district meeting, or the great medical association circuses where an indigestible mixture of medical papers competes with the exigencies of medical politics and a strenuous social program. Rather I am thinking of educational opportunities planned with the effort and sophistication we now reserve for undergraduate and graduate teaching, and offered to practitioners who set aside a definite proportion of their time for systematic participation The day-long symposium on a single subject with part of the day spent in small group discussions can be helpful. Or a man might spend a week or two attached to a teaching hospital — and if necessary he could be offered the services of a resident who might cover his private practice for this period as a useful supplement to his own training

We can do all these things and more if we think it important. But to do them we must support our medical schools in obtaining additional faculty and funds to carry them out properly. I think myself that a vigorous program of Continuing Education is so important that we cannot solve our educational problems without it.⁶⁰

An important part of the continuing education process — perhaps the most important part — is the association of the practising physician with the life and

⁵⁹Brief to the Committee on the Healing Arts.

⁶⁰Dr. D. L. Wilson, *op. cit.*, p. 279.

work of a large hospital. In this respect, Departments of General Practice, for which the College of Family Physicians has been constantly pressing, may constitute a focal point for further advance. Some leaders in the field urge that selected community hospitals should become the primary focus of continuing education, perhaps with outlying hospitals associated as "satellites" for the purpose of reaching a greater number of doctors.

Forty-one per cent of the Ontario doctors in Clute's study claimed to attend postgraduate courses "regularly" and most valued them highly; hospital staff meetings, local medical society meetings, and CMA conventions were less highly regarded. Conventions were criticized for concentrating on specialists' problems and being too big; local medical society meetings were criticized for being for business only, or "mainly social". A high proportion of the sample did little reading, and one doctor said that the only source of information he found of "great value" was the publications of the drug companies.

One physician told us that he spent fifty dollars a month on long distance telephone calls. Whenever he was in doubt or difficulty he did not hesitate to call and ask the advice of one or other of a group of consultants who were members of the staff of a medical school. In addition, whenever he visited the city, he made it his habit to go round the hospitals (asking questions)⁶¹

This man's practice was geographically "one of the most remote from a medical school". On the other hand, Clute found doctors "even in the heart of a large city" who gave the impression of almost complete isolation.

"We hold," says Clute, "that keeping up with medical advances is an essential part of the practice of medicine." It appeared

. . . that some practitioner's difficulties in keeping up . . . were the result of lack of stimulation, which, in turn, was the result of professional isolation. This we regard as one of the strongest arguments against any system of medical practice that would exclude a general practitioner from the work of a hospital.⁶²

All the doctors in the smaller towns and more rural areas that we spoke to said the same thing.

Professional isolation is a matter to which we direct attention in Chapter 13 (on medical practice), since it is bound up with the problem of the distribution of doctors and the organization of their practices. The objective of continuing medical education is, in part, to take the doctor out of his professional isolation and to bring him back, from time to time, into the mainstream of professional advance. But this is impossible for many doctors in solo practice unless an

⁶¹K. F. Clute, *op. cit.*, p. 455.

⁶²*Ibid.*

organized effort is made to provide them with the necessary relief. Therefore, the attack apparently has to proceed on two fronts simultaneously: a reorganization in medical practice, and a more coordinated attempt to provide facilities for continuing education in a form, and in the places, where they will be most readily available to the largest number of practitioners.

Appendix VI

College of Family Physicians of Canada

Guide for Estimation of Postgraduate Study Credits

General Consideration

The minimum requirement for active membership in each two-year period after admission to the College is 100 hours, of which at least 50 hours must be obtained through study activities described in Section I.

Estimate hours of study credits as hour for hour of instruction, unless otherwise stated.

If for any reason a member has had undue difficulty in compiling sufficient studies for a two-year period, he may have a year of grace in which to make up the deficiency.

Your current membership card is designed to serve as a memoir of medical meetings attended during the year. If you or your secretary keep this card up to date, you will be agreeably surprised at how easily you can prepare your report at the end of your membership year. You may use this card for your final report, or you may report on a separate sheet — whichever you prefer.

You are requested to make use of the "Attendance Record" available at all assemblies, clinical days, lectures, etc. . . . sponsored by the College. These will assist you in recording your study credits.

Section I

That a minimum of 50 hours of study credits must be obtained from the following sources:

1. The Annual Scientific Assembly of the College of General Practice and/or a Provincial Chapter.
2. University initiated, sponsored and approved courses.
3. Courses conducted by recognized medical teachers.

4. Annual Convention of the CMA, l'Association des Médecins de Langue Française du Canada, and Provincial Medical Societies.
5. Courses initiated, sponsored or approved by the College of General Practice or its Provincial and Regional Chapters.
6. Other formal training that may be acceptable to the National or Provincial Education Committees of the College.

Section II

That the remaining 50 hours may be acquired through study activities described below:

I.C. (Individual Consideration).

1. Other medical programs which are of high educational, ethical and medical standards. (I.C.)
2. The publication of an original scientific paper in any recognized medical journal. (I.C.)
3. The presentation of an original scientific paper at a recognized medical meeting. (I.C.)
4. The preparation and presentation of a scientific exhibit at the provincial level or above. (I.C.)
5. Research. (I.C.)
6. Correspondence Courses. (I.C.)
7. Participation singly or in groups in recorded medical lectures. (Tapes and Discs.) (I.C.)
8. Planned reading. (Books and Journals.) (I.C.)
9. Teaching medical students and internes. (I.C.)
10. Preceptorship. One hour per day: maximum 15 hours annually.
11. Member of a Family Care Program. (I.C.)
12. Member of a Department of General Practice, including services in an O.P.D. (I.C.)

N.B. — Excess credits earned in a higher category may be applied to a lower category.

Membership activities in medico-legal, medico-economic and medical lay organizations do NOT provide Study Credits.

Chapter 13 Medical Practice

We trust our health to the physician Such confidence could not safely be reposed in people of a very mean or low condition

—Adam Smith, *The Wealth of Nations*

In this chapter, we take up again, in greater detail and with specific reference to Ontario, some of the trends in medical practice that were sketched in Chapter 1, beginning with the twin problem of the supply and distribution of doctors in the province.

Supply and Distribution of Doctors in Ontario

The doctor-population ratio is generally regarded as a crude indicator at best. Most obviously, it tells us nothing about the number of doctors who are actually available to see patients. The present ratio in Ontario is about 1:750, but this includes insurance and drug company doctors, medical bureaucrats, medical administrators of hospitals, full-time medical teachers and research scientists, medical officers of health, doctors working for insurance plans, and others. According to a CMA survey in 1967, doctors in these “non-patient-care” categories constitute a fifth of all doctors in Canada. The OMA suggests that only about 55 per cent of all doctors in Ontario are available for first contact care. This, from many points of view, is the figure that matters.

Second, the distribution of doctors is important: the doctor-population ratio varies widely from one part of the province to another. Dr. Judek¹ found that the concentration of doctors in the large urban centres is greater than that of the people as a whole. In 1962 about 90 per cent of the active doctors in Ontario were located in communities of 10,000 or over, compared with 67 per cent of the population. Putting this the other way round, the 33 per cent of Ontarians who lived in the smaller communities and rural areas were looked after by less than 10 per cent of the doctors.² At that time 53 per cent of the people of the province lived in nine metropolitan areas,³ and they were served by 70 per cent

¹S. Judek, *Medical Manpower in Canada*, Royal Commission on the Health Services, Queen's Printer, Ottawa, 1964.

²For those who look to immigrant physicians to solve the problem of the remoter areas, it should be noted that only 12 per cent of immigrant doctors in Ontario in 1962 were located in communities of 10,000 or less — scarcely more than the physician population as a whole.

³Hamilton, Kingston, Kitchener-Waterloo, London, Ottawa City and Eastview, Oshawa, Sudbury, Toronto and Windsor.

of the province's doctors. The ratio for the province as a whole was then 1:774; that for the metropolitan areas, 1:590. But there were considerable variations within the metropolitan nexus itself: in Kingston the ratio was 1:288; in Toronto it was 1:578; while in Sudbury it was 1:858.⁴ Putting this another way: in Toronto 39 per cent of the province's doctors looked after 29 per cent of the population of the province; in Sudbury 1.6 per cent of the province's doctors looked after 1.8 per cent of the people (a figure, incidentally, that puts Sudbury's "shortage" in a slightly different perspective).

These figures must be interpreted with care. If one looks at the distribution of doctors by counties and census divisions (as Dr. Judek did), it is evident that the proportion of doctors to population is more favourable in the highly urbanized counties than it is in the largely rural ones. This follows from the fact that it is in the former that most of the specialist and hospital-based services are located. A rural or small-town community is not necessarily "short of doctors", however, if it is close to a large urbanized area, even though its own family physician ratio may be poor. To get a more accurate picture of the shortage of doctors in Ontario as a whole, it would be better, perhaps, to compare the worst areas of the province with the best areas of similar type in other provinces. In mainly rural Saskatchewan, for example, the proportion of general practitioners to specialists is about 2:1, the reverse of the more urbanized provinces (the medical militancy of the province is, no doubt, partly due to this fact).

A further problem that gross doctor-population ratios tend to conceal is posed by the continuing imbalance between family physicians and specialists. If the proportion of general practitioners to specialists in private practice in Ontario continues to decline,⁵ the situation in the smaller communities is bound to worsen, since the concentration of specialists in metropolitan areas is much greater than that of general practitioners. Even as long ago as 1954, 86 per cent of the specialists in private practice were practising in communities of 10,000 or more, compared with only 52.5 per cent of the general practitioners. The recent CMA survey shows that 53 per cent of all doctors are located in areas of more than 100,000; 85 per cent of the specialists practise in communities of more than 25,000; and 30 per cent of the general practitioners practise in communities of less than 5,000. One-third of all the general practitioners in the twenty-five to thirty-four age bracket practise in such small communities (a figure which casts some light, incidentally, on the impressionistic picture of small towns as being almost exclusively staffed by aging doctors who qualified during the Depression or earlier). More first-contact medicine of all kinds is done in the more rural parts of Ontario. According to an OMA survey in 1966, from 66 to 74 per cent of the doctors in

⁴These figures illustrate, incidentally, how unrealistic overall ratios can be — the Kingston ratio is low because of the medical school and teaching hospitals, but ask any newcomer to Kingston who tries to get a family doctor about "doctor shortages".

⁵In the past ten years Canada has certified more specialists every year than it has graduated new doctors from the medical schools.

these parts were seeing patients without referral, whereas in Metro Toronto the proportion was only 44 per cent.

The doctor-population ratio leaves out of account many factors which cannot be determined by simple "nose-counting". It tells us nothing about doctor-productivity or effectiveness, for example, and nothing about the help the doctors may be receiving from other health personnel. Nor does the "population" side of the equation tell us anything about effective *demand*. The uncertainty about medicare, for example, means that no one can be sure what demand per head will be in the next few years. The usefulness of the ratio is further reduced because what is an "adequate" ratio seems beyond definition — i.e., no one can say what this ratio *should* be. The Hall Commission adopted the magic figure of 1:875. The CMA suggests that by 1980 Canada should have an overall ratio of 1:795. What usually happens is that the ratio *as at some base date* is selected as the norm (the Royal Commission on Medical Education in Britain has just done this).⁶

As Dr. Judek points out, however, the overall doctor-population ratio has some useful applications if it is used with discretion, particularly as a guide in comparing provinces and large regions. The Ontario ratio is one of the best in Canada. Between 1951 and 1965 the population of Canada increased by rather less than six million while the doctor-population ratio fell from 1:976 to 1:825. (As we have seen, this was almost entirely due to the influx of immigrant physicians.) In Ontario the population increased by about two million and the ratio fell from 1:857 to 1:744. This is a better ratio than any other province except B.C., where it is roughly the same. Thus, relatively speaking, there is no shortage of doctors in Ontario: that is to say, *in relation to the other provinces*. (But this again tells us less than we would like. The ratio has improved hardly at all since 1961; and it is, in fact, only marginally better than it was fifty years ago — 1:828 in 1911 — although there have been vast changes in medicine and in the organization of medical practice.)

There is no doubt, however, that there *are* relative shortages between various parts of the province, *within* the larger urban areas, and between types of doctor and specialty. Geographical maldistribution hardly needs documenting, but the following "cases" are among those that appeared in the press in 1967-1968. Wingham, a community of 3,000 people a little to the west of, and midway between, Owen Sound and Kitchener-Waterloo, lost two of its four doctors when they moved to London, sixty miles away. They left behind one invalid doctor, whose illness was "brought on by overwork", and the local coroner, who "takes three-month holidays every winter" and wishes to retire. A special town committee "scoured Ontario" to find replacements. But, the mayor said: "Listowel,

⁶The Todd Commission (the British Commission) selected 1961, because it was in that year that the best ratio so far was achieved. The ratio has, in fact, fallen since then, though with what consequences no one knows. (See Gordon Forsyth, "Making Better Doctors", *New Society*, April 11, 1968.)

twenty-one miles east of here (it is midway between Wingham and Kitchener) has nine doctors." Wingham eventually got its two replacements — both, reportedly, from Marathon, a tiny place between Sault Ste. Marie and the Lakehead! Marathon, in turn, got *its* replacements (one an immigrant doctor as yet without a full licence to practise). It would be interesting to know how extensive is this practice of poaching, which does nothing to improve the general situation. In August 1967, the mayor of Wingham reported that: "The shortage of doctors hasn't been nearly as bad as we expected . . . we are all very happy."

Less happy was Wawa, population 5,000, with two doctors, both threatening to leave. The local clerk said the township had advertised and had received one application from an English doctor "now practising in the United States". He was willing to come but did not want to put in a year working under an Ontario doctor's sponsorship before being allowed to practise on his own (see Chapter 8). Less happy, too, were the northern communities of Hearst and Beardmore, the former reportedly with three doctors serving a population of 12,000. In Sudbury (well equipped with hospitals and with a politically active medical community, but "not an attractive city for medical graduates")⁷ the G.P.-population ratio is said to be 1:3,000, twice the figure generally recommended and allegedly "the worst outside Metro Toronto (sic)".

Unfortunately, we lacked the time and resources required for a detailed study and proper assessment of the situation — that is to say, from area to area throughout the province. Our impression is that grave shortages may exist in places of which the public hears little, while in others minor deficiencies may be exaggerated by vocal residents and/or the local medical community. If one can believe some of the complaints, there are parts of the province that will shortly resemble ancient Babylon, of whose inhabitants the historian Herodotus wrote:

They have no physicians, but when a man is ill, they lay him in the public square, and the passers-by come up to him, and if they have ever had his disease themselves, or have known anyone who has suffered from it, they give him advice recommending him to do whatever they found good in their own case, or the case known to them. And no one is allowed to pass the sick man in silence without asking him what his ailment is.

Our own inquiries took us to North Bay, where the following information and opinions were volunteered by a local doctor.⁸

There are nineteen doctors actively in general practice in North Bay, serving an area of approximately 55,000 people, a ratio of roughly 1:2,800. Dr. ——— has about 2,500 on his list.⁹ He says he is busier than he would like to be (he is a man in his thirties), but no busier than a Toronto doctor or any doctor in a town comparable to North Bay. On an average day he sees twenty-five patients

⁷According to the President of the local medical society.

⁸What follows is taken verbatim from the notes of one of our research assistants.

⁹This would compare quite favourably, say, with a National Health Service doctor in Britain.

in his afternoon surgery (from two to six p.m.). In the morning he visits his patients in hospital, and in the evening makes a few home visits. Altogether he sees about forty patients a day. There are no anaesthetists in North Bay, so a few of the G.P.'s take turns at the hospital giving anaesthetics for about three hours a day. One of the four doctors in his group (practice) does this. A six-month training in the hospital is all that is needed. Areas short of doctors known to Dr. ——— include Mattawa (on the Ottawa Valley Route, forty miles from North Bay): there are two doctors for 8,000 people. One of these doctors is ill, so when the other is not available the patients have to come to North Bay.¹⁰ He thinks group practice is the only answer: his has four doctors, all young men. When one of them left the practice in 1966 they asked the OMA for the names of doctors who might be willing to join them. Nothing happened. They filled the vacancy through family connections.

Of the factors influencing a doctor's decision about the location of his practice, Dr. Judek mentions the following: income per head of local population (one beneficial effect of comprehensive medical insurance is that it lessens the pull of "rich" communities — at any rate, merely because they are rich — which has traditionally tended to distort the distribution of doctors); effective demand for medical care; medical school attended and place in which internship and residency was done; place of residence before entering medical school; accessibility of hospitals, and hospital privileges; climate and topography of the area; social and cultural amenities, housing, schools, and so on.¹¹ We have commented at various points in this report on the possible effects of these factors, especially the influence of the doctor's home town when he entered medical school, the influence of the medical school, and the location of the hospitals in which he interned, as well as the availability or non-availability of hospital privileges in the area.¹²

In 1962, in Canada as a whole, roughly 30 per cent of Canadian-born doctors came to medical school from communities of under 10,000; 54 per cent came from cities of 100,000 or more. Approximately half of those who came from communities of less than 10,000 set up their first practice in communities of similar size. We noted earlier (in Chapter 12) that the large Ontario cities contribute more students to its medical schools than they get back in the form of graduates — i.e., not all the "big city" boys are attracted back to big cities. We noted also that the OMA study (of the 1950-1951 entering class of medical

¹⁰Compare the case in Appendix I, Chapter 5: that area was in eastern Ontario.

¹¹There are obviously others: one interesting one in suburban Toronto appears to be municipal zoning restrictions which operate against the establishing of group practices in residential districts (see, for example, "North York Planners discuss M.D. shortage and zoning problems", *Toronto Globe and Mail*, June 26, 1967).

¹²The North Bay doctor we quoted said that he would leave if the local doctors' hospital privileges were taken away because "he enjoyed his hospital work", and that he wouldn't come to Kingston "at any price" (this was at the time of the Kingston "bed-crisis").

students) showed that, while 35 per cent entered from places outside the metropolitan areas, 25 per cent of the class were still practising outside these areas ten years later.

A recent study by Dr. John Last, of the regional distribution of general practitioners in the British National Health Service, was designed in part to test the hypothesis that doctors settle near the place where they lived in their youth rather than near the medical school they attended, if these were in different regions (the dominance of London medical schools perhaps makes Britain unique in this respect, though in Ontario the dominance of the University of Toronto may supply some parallels).¹³ The findings confirmed the hypothesis, and this led Dr. Last to suggest that a region short of doctors might be helped more by recruiting larger numbers of students from families resident in the region than by establishing a local medical school: the solution would be cheaper and would perhaps produce quicker results. It is not suggested that this would necessarily be appropriate in Ontario, but it is an idea that is worth following up.

A closer look at medical school recruitment policy might therefore be appropriate. In his report to the Hall Commission, Dr. Judek suggested other possible ways of alleviating the problem of maldistribution. These included:

- 1) The establishment of a physicians' placement service (the OMA now has its own, but this does not work effectively).
- 2) Extending the facilities for continuing education for rural physicians, to keep them in closer contact with the larger medical centres (this, as we have seen, is one of the functions of the College of Family Physicians as well as of Departments of Continuing Education in the medical schools; but the crux of the matter is to find ways by which the rural physician can be relieved from time to time so that he can get away from his practice).
- 3) Creating small clinics (essentially group practices), strategically located in rural areas and with access to consulting services from the larger medical centres, in place of the present scattered solo practices and two-man partnerships.
- 4) The assumption by rural communities of greater responsibility for attracting doctors, in part by providing housing, offices and basic equipment at low rents. (Some Ontario communities are already active in this way, but it is not in the public interest that they should compete with each other in an unregulated manner.)

¹³J. M. Last, "Regional Distribution of General Practitioners and Consultants in the National Health Service", *British Medical Journal*, June 24, 1967, pp. 796-799. Incidental findings of interest include the following: approximately 20 per cent of the sample of G.P.'s and specialists came from "medically qualified" families (this is perhaps twice as high as Canada), though this rate is now falling (i.e., the percentage is boosted by older doctors qualifying before the Second World War; the percentage declines among recent graduates); and general practitioners are more likely to follow in their father's footsteps than specialists.

- 5) Subsidization by the provincial government (perhaps with municipal assistance) of rural physicians' incomes, or direct employment of physicians on a salaried basis (the latter, which may well be the ultimate answer, would, of course, arouse fierce opposition from the OMA).¹⁴

It is perhaps worth noting the creation, in Britain, of a General Practice Finance Corporation, which makes loans to G.P.'s to help them acquire, adapt, improve or build premises. This kind of device, selectively used with an element of subsidy and perhaps combined with group practice requirements, might well encourage young doctors to locate, at least initially, in rural areas.

The situation in regard to the supply of *specialists* is complicated, as we have seen, by the fact that some certificated specialists, particularly those in the smaller urban centres, do not restrict their practice to their speciality but engage (to a greater or lesser extent) in general practice as well. This is true particularly of the paediatricians, internists, and obstetricians and gynaecologists. On the other hand, some general practitioners (again mainly in the smaller urban centres and outlying rural areas) practise a *de facto* specialty on a part-time basis, generally in association with the local hospital. In fact, Dr. Judek's figures show that the percentage of *non-certificated* *de facto* specialists continues to rise (it roughly doubled in the decade from 1951 to 1961). Figures supplied by the Royal College of Physicians and Surgeons in a brief to the Committee on the Healing Arts show, at the same time, a dramatic rise in the number of Fellows and Certificants in Ontario.

	<i>Fellows</i>	<i>Certificants</i>
1950	135	438
1961	882	2,210
1966	1,277	2,945

Taking the Royal College figures by specialty, the following picture emerges as of April 1966. The ratio of *anaesthetists* to population (1:18,400) was better than in any other province except British Columbia, markedly better than in the Prairie Provinces and significantly better than in Quebec (1:19,500). In *bacteriology* Ontario was second to British Columbia and Quebec (1:126,000, compared with 1:122,000 in the other two provinces). Ontario was short of *cardiovascular and thoracic* surgeons (though the number in the whole of Canada was only 76), having a ratio (1:310,000) worse than any region except the Maritimes. In *dermatology* (1:99,000) only British Columbia and Manitoba had better ratios. In *general surgery* (1:9,000) Ontario again came third, this time to British Columbia and New Brunswick (many general surgeons in New Brunswick, however, do general practice). In *internal medicine* Ontario, with a

¹⁴See, for example, the OMA's reaction to the attempt to establish a salaried service clinic in Sault Ste. Marie a few years ago.

ratio of 1:11,300, ranked fourth after Quebec, B.C. and Manitoba. In *neurology* the province came second to Quebec (1:52,500). In *neurosurgery* it ranked sixth (1:244,000) after B.C., Saskatchewan, Alberta, Quebec and Manitoba, in that order. It had the best ratio in the country (1:18,100) in *obstetrics and gynaecology*, and was second only to B.C. in *ophthalmology* (1:32,500). In *orthopaedic surgery* it ranked fifth (1:55,100) after B.C., Alberta, Manitoba and Quebec, in that order; and third,¹⁵ after B.C. and Quebec, in *otolaryngology* (1:39,200). Ontario came third to B.C. and Manitoba in *paediatrics* (1:24,300), and second only to B.C. in *pathology* (1:39,000). The province ranked sixth in *physical medicine* (1:402,000), only Manitoba having a worse ratio if one excludes most of the Maritimes (New Brunswick had only one such specialist, P.E.I. and Newfoundland had none; Nova Scotia, with two, had a ratio of 1:380,000). With a ratio of 1:175,000, Ontario had more *plastic surgeons* than any province except B.C., and the best ratio in the country (1:17,500) in *psychiatry*. It was second only to B.C. in *diagnostic radiology*, with a ratio of 1:24,000; but ranked fourth (again excluding the Maritimes) in *therapeutic radiology*, with a ratio of 1:71,200, and also in *urology*, with a ratio of 1:57,900.

The province had a ratio better than the national average in all specialties except cardiovascular and thoracic surgery, neurosurgery, orthopaedic surgery, physical medicine, and therapeutic radiology; but it ranked after British Columbia in all specialties except neurology, obstetrics and gynaecology, and psychiatry; and it ranked after Quebec in bacteriology, cardiovascular and thoracic surgery, internal medicine, neurology, neurosurgery, orthopaedic surgery, otolaryngology, physical medicine, and therapeutic radiology.

Comparing the 1966 figures with those of 1961, only bacteriology showed a *worsening* in the specialist-population ratio; neurology showed a spectacular improvement; and marked improvements were made in orthopaedic surgery, pathology, plastic surgery, diagnostic radiology and urology.

The figures tell us little beyond the relative distribution of the specialties; and they reveal nothing about actual needs.¹⁶ These are not easy to assess: though it has been said that there is a national shortage in practically every specialty except general surgery and therapeutic radiology.¹⁷ The Royal College has a Committee on the Supply and Distribution of Specialists; but not unnaturally, given the College's function, it tends to look at the question from a national and regional rather than from a specifically provincial point of view. In any

¹⁵Fourth if one includes Prince Edward Island, which, with three otolaryngologists, had a ratio of 1:36,000!

¹⁶They are also "out of date": private evidence given by the Royal College to the Committee on Healing Arts, November 13, 1967. Nor do they tell us how many of these specialists are treating patients. According to one source, only one out of thirty psychiatrists today is in active practice. The rest are teaching or doing research.

¹⁷Private evidence given by the Royal College to the Committee on Healing Arts, November 13, 1967.

event, it has no executive authority to guide the flow of specialists within the provinces. The flow of recruits to the various specialties tends to (belatedly) follow the market, according to the laws of supply and demand, although the College does attempt to give "a very limited amount of guidance", chiefly in correspondence with candidates:

. . . many of whom — well, not many, but some — ask where the deficiencies in specialty practice may lie, and which fields are short of manpower and so on. We have general ideas of where the shortages are most acute, and we might advise a candidate of the fields which appear to be short of specialists. But, the question of manipulating supply and demand through the College is, to the best of my knowledge . . . something that is not proper for this College to consider.¹⁸

The College certainly exercises some influence on supply by means of its accreditation program and, of course, in its conduct of examination curricula; but quite as much, and perhaps more, influence lies with the heads of the various specialist departments in the hospitals. The College

. . . can provide the information (about relative shortages) and this will influence the trainees, I suppose, and also influence the training programs.¹⁹

But it is reasonable to expect that the greatest informal influence is exercised by the department heads who, after all, have to make decisions about what, and how many, trainees in a particular specialty they are willing and able to accept, given training specifications and the operational needs of the hospital at the moment.

I suppose the most direct way (to influence the situation) would be by monetary inducement . . . but this would have to come from sources other than the Royal College.²⁰

Quebec is at present the only province that has its own specialty-licensing (or, more strictly, certifying) body. A multiplication of provincial specialist bodies would, not unnaturally, be unwelcome to the Royal College; and it might (in any case) be contrary to the *national* interest, even were reciprocal arrangements to be worked out (as is happening between Quebec and the Royal College at the present time). But, as we have noted, the Ontario College of Physicians and Surgeons is already, in Ontario law, the one provincial body that is empowered to "recognize specialists". The demand for firmer central guidance of the specialties *within the province* suggests that this is an area of activity which the Ontario College might be encouraged to expand. It would, however, be necessary for it to work closely with the Royal College and with the Ontario Council of Health.

A consideration of the overall "shortages" of doctors in the province is best left until after we have looked at trends in the shape and content of medical practice.

¹⁸See footnote 17.

¹⁹See footnote 17.

²⁰See footnote 17.

Problems of Medical Practice

In 1962,²¹ 35.5 per cent of the active doctors in Ontario were in general practice. A further 32 per cent were in private specialist practice or consultancy. Nearly 11 per cent were interning or in residencies. Hospital doctors accounted for a further 9 per cent, research and teaching for 4.5 per cent, and just under 5 per cent were in public health and industrial medicine. The remaining 3 per cent were said to be in "other employment", including, presumably, the pharmaceutical industry, insurance and the like. The first major change that has taken place since the Second World War is in the number of doctors employed full-time in hospitals, and in teaching and research. In the twenty years from 1943 to 1962 the percentage employed in teaching and research in Canada as a whole increased from 1.4 per cent to 4.1 per cent; the percentage in hospitals increased from 5.2 per cent to 9.5 per cent. The percentage of doctors employed in industry and in public health, on the other hand, showed little change. The second major change, of course, is in the balance between general practice and the specialties. Enough has been said about this already. We merely note that in the twenty years from 1943 to 1962, the percentage employed in general practice fell from 68.4 per cent to 34.7 per cent while the percentage employed in private specialist and consultancy practice rose from 16.7 per cent to 32.6 per cent.

While very few doctors move from other forms of medical employment to general practice, there is a significant movement the other way. There is thus a major problem of *retaining* doctors in general practice.²² Nearly a quarter of the Hall Commission's sample of specialists, in 1962, came from the ranks of the general practitioners. Here is how one doctor sees the problem:

How are we to keep family practitioners in practice? Too often, we see the following pattern. A young man graduates in medicine, probably in debt, and often married, internes one or two years, and then enters family practice, often because it is the easiest and quickest way out of debt. He settles, starts into practice, and may go deeper into debt, and then works furiously for five years to become solvent.

In many communities he may work several evenings a week, as many of his confreres do, build up a large practice, seldom see his family, buy a \$30,000.00 house, and a big car, and be on top of the world. But what good is the view if he never has time to look about?

If he continues on a few more years, he may find his family life in difficulty, suffering from the lack of a father. Sooner or later he becomes exhausted and starts looking for a way out. His wife is nagging him for never being at home and his patients seem to be constantly harrasing him. He finds it increasingly difficult to say no to patients, who learn that with

²¹These figures are taken from S. Judek, *op. cit.* We should note that the sources for 1943 and 1962 are different, and comparisons may therefore be somewhat misleading.

²²As against the problem of recruiting them in the first place, which is a matter we considered in Chapter 12, on medical education.

pressure, they can be seen that day. He may "work in" enough people to turn a busy day into an impossible one. His office is full, and he dreads going to the office. He finds he must leave town to get any peace. He finds himself hurrying patients through, just to get finished for the day. His conscience pricks him for the deterioration of his work habits. If there ever was a rat race, he is in it. For many doctors, the way out of this morass is sought before ten years of practice is up, and (he) "escapes" into the shorter hours, greater income and prestige, and higher calibre of practice that he envisions in the yonder green pasture. He may of course be bitterly disappointed ten years later to find he is now called a specialist, but does General Practice to make a living, works just as hard as ever and has to give more of his time to "Staff Work" and administration. A Fellowship doesn't make him a better father either, necessarily.

Those who choose to remain in such a position in family practice look for several alternatives — a series of partners, an expanding clinic, pseudo specialization, or they merely fight a losing battle against the volume of work "that has to be done".²³

We have already discussed the educational aspect of this problem. But there are other factors to be considered too: improvement in the working conditions of the family practitioner is as important, no doubt, as improvement of his public image and his professional competence.

The evidence on "overwork"²⁴ is conflicting (it may well indicate wide differences in work habits within the profession). The CMA "manpower census" (the survey to which we have made frequent reference in this report, and which is now nearing completion) shows that about a quarter of all doctors work fifty to fifty-nine hours a week; another quarter work sixty to sixty-nine hours. The general average is sixty hours a week (which apparently is unaffected by size of community), and most doctors claim to handle 100 to 125 patients a week (declining to about eighty patients a week in the central areas of larger cities). The Judek survey showed fifty-two hours as the average for general practitioners,²⁵ forty-three to forty-four hours as the average for specialists and consultants.²⁶

²³J. A. Collyer, "How're Ya Gonna Keep 'Em Down on the Farm", *College of General Practice of Canada Journal*, August 1966, p. 23. Dr. Collyer was then practising in Leamington, Ontario and was Chairman of the College's Ontario Chapter Advanced Training Committee. It is relevant to note that the death rate for doctors is slightly higher (from one-and-a-half to two percentage points higher) than for the male population as a whole, in the age range 45-64. Above (and below) those ages, there is little significant difference. Diseases of the heart and cirrhosis of the liver are among the major killers.

²⁴Dr. Collyer suggests, interestingly, that doctors may learn some of their irregular work habits from their interne days, when they "hero-worship 'chiefs' who insist on their residents working fourteen hours a day, and establish local legends by making 7 a.m. and 10 p.m. rounds".

²⁵This also tallies with Clute's figures, which were 52.5 for Ontario and 60.2 in Nova Scotia. There were enormous variations, however: in Ontario, hours worked ranged from 23 a week to 103 a week.

²⁶A 1965 survey by the (British) College of General Practitioners found that the average English G.P. worked a forty-hour week, a finding supported by a later survey. This is much less than is popularly supposed — and less than British doctors themselves claim to be doing.

"On-call" time is not included in any of these figures; but it is hard to say what "on-call" time amounts to. Doctors claim much for it — patients who have ever tried to get a doctor "after hours", on the weekly Doctors' Afternoon Off (usually Wednesdays or Thursdays) or at weekends, on the other hand, are not impressed. Since hours on call are not included, and (by inspection) we know that urban doctors, at least, do not work weekends or on one afternoon a week, the average *workday* must be of the order of eleven to sixteen hours. But it must not be forgotten that the average urban doctor takes at least four weeks' holiday a year, which is more than the average business executive, and probably more than most professional people (including professors). This is not to suggest that the doctor is to be begrudged a proper rest, but it is a factor which needs to be borne in mind. The question is, says Dr. Ross Matthews, a former President of the OMA, "whether in a society where the forty-hour week is already under pressure, he (the doctor) is willing to continue to be so far out of step?"²⁷ The question is also, surely, whether it is really necessary for the doctor to work such long hours. (It is also salutary to point out that the forty-hour week is not typical of professional men, particularly the self-employed, most of whom work much longer.)

One British doctor, writing in *The Lancet*, had this to say:

Many people would expect that the most striking impression made upon the mind of a traveller would come from the differences that are to be found in general practice in other countries. In fact, the similarities surprised me, particularly the recognition that the major problems that we face are to be found in each of the countries that I visited. High upon the list is the increasing demand made upon the general practitioner's time.

Most family doctors . . . believe that the burden of work that they are asked to carry is already too great and often clinically unsatisfying. To these doctors, talk of lengthy vocational training and expansion of their interests into new fields of medical care seems, to say the least, highly unrealistic. Doctors in other countries may adjust the demand made upon them by restricting their work and raising their fees. Under our present system this is not possible here: in any event, medical opinion has long accepted the principle of responsibility to the whole community. The idea of offering high-quality care to only part of this community is unacceptable. Yet, in the face of a diminishing number of doctors and an increasing number of patients, the profession seeks a reduction in the number of patients for whom each practitioner is responsible, and whose demands for health care grow greater year by year.

The decrease in the proportion of doctors choosing general practice as a career is well documented in every country. This has now become a medical fact of life . . .

If, then, it is impossible to increase the number of doctors to keep pace with rising demands, and unacceptable to restrict that demand to part

²⁷Ross Matthews, "Manpower, Demand and Medical Care", *Ontario Medical Review*, September 1966, p. 649.

of the community, there are only two possible solutions. One is to restrict the demand for general-practitioner services. A policy of economic sanctions applied to some or all of our patients might hold back the flood-tide of demand for a while, but a sophisticated society seeks protection against ever more unlikely hazards, and the provision of this protection demands a progressively disproportionate effort in money, time, and manpower. So this solution, however laudable . . . is, at best, a temporary expedient.

The second solution is to redistribute the work to enable a smaller number of doctors to look after a greater number of patients in a different way. We may then argue that we have too many, not too few, family doctors . . . but that they are used inefficiently.²⁸

Dr. Drury goes on to point out that the family physician is the most nearly self-sufficient of all health workers, but that the need to apply his special skills to as large a number of people as possible requires the development of the skill of delegation; even so, the doctor must remain the leader of the team, and must appoint and administer them.

In forty-three general practices that I visited, I never met a doctor who did not have at least one trained, full-time, non-medical assistant, and the majority had more than one. In one health centre in Yugoslavia, twelve general practitioners were supported by nine public-health nurses, twelve auxiliary nurses, and four clerical staff. In the district of Rijeka, each general practitioner had two nurses, one auxiliary nurse, and a secretary. In West Germany, in one practice, two doctors employed twelve non-medical assistants. They had 35,000 doctor-patient contacts yearly. The picture was the same in the U.S.A. A practice of six doctors had twelve registered nurses, six receptionist-secretaries, and four technicians. They had 54,000 patients on their "books". Another in a rural area employed nine trained assistants for two doctors. They saw 2,000 patients a month and cared for virtually all who were admitted to hospital.²⁹

In Britain, in 1964, the full-time consultant was supported by two other full-time doctors, thirty-five full-time nurses and midwives, four technical staff, and supporting clerical assistants: the average family doctor was supported by less than one full-time helper.

Dr. Drury goes on to discuss the kinds of help that the family doctor needs (the implication is that he works in a group with other doctors). There are now training courses for *medical secretaries* in a number of West European countries including Britain,³⁰ as well as in the United States. She is clearly important to the "managerial" side of the practice. The medical secretary has (or should have) considerably greater responsibility and skill than the average receptionist (one or two of whom also may be needed in a large practice), and she should not be

²⁸Michael Drury, "Work Load and the General Practitioner", *The Lancet*, October 14, 1967, p. 823.

²⁹*Ibid.*

³⁰British colleges of further education are said to be training approximately 1,000 medical secretaries a year for hospital and general practice work. The training leads to the Diploma of the Association of Medical Secretaries.

expected to combine the roles of receptionist, instrument sterilizer and general medical assistant, as many receptionists (sometimes inefficiently) currently do. The nursing role needs to be redefined: what is required, Dr. Drury argues, are *family nurses* — not nurses of the old “voluntary order” or “district” type, but a new kind of general practice nurse. Much that the present doctor does would be well within the capacity of a trained family nurse, work which would be much more than “semi-skilled patient care”. Dr. Drury suggests, in effect, that what might be called “first contact health team care” should rest with her: that is to say, it should be an important part of her work to consult with and refer to the social worker, the specialist health worker, the public health nurse, and so on, in the community. These specialists should not be employed in the practice itself. His argument is that “a team with too many (different kinds of) members produces committee type, impersonal service”.³¹ The new-type family nurse might well be recruited from the ranks of the “lost nurse” — the married nurse who does not return to work at present because she has lost confidence in her ability after being unemployed for so long.

Dr. Drury’s “health team”, therefore, would consist of a group of family doctors, family nurses, and supporting medical secretaries and other administrative staff. He argues that “specialisation at the point of contact” should be avoided. If it is avoided, it should be possible to combine preventive and curative care, and to “give meaning to the description of family practice as comprehensive”.

Much has been written on group practice, and in 1968 the CMA completed a major study. Though solo practice is still the commonest form (55 per cent) in all sizes of communities, group practice now accounts for about 30 per cent of all practising physicians in Canada, and some people confidently predict that it will replace solo practice altogether in the next generation. It may bring substantial economic gains (for example, a pooling of physical resources, equipment and ancillary staff) and certain psychological gains for the individual physician in terms of security, greater opportunities for relaxation, contact with fellow physicians, and potential gains in efficiency (time off for study, and so on). Group practice, however, varies widely, ranging in form from very large clinics, some of them seeking incorporation, employing forty or more doctors and encompassing the services of specialists as well as family doctors; through multiple specialty and single specialty groups; down to small groups of three or four general practitioners which are not much more than partnerships. The methods of payment also vary: from income-sharing arrangements, through a salary system, to fee-for-service, where each member continues to receive his own earnings, less a proportion of the overheads.

There are certain potential defects. There is danger that the patient will suffer from “assembly-line” treatment; he may have to travel farther to reach his

³¹This view runs counter to the increasingly accepted view that social workers and perhaps other specialists too should be members of the group practice team.

doctor; and he may become just another "case", losing the personal touch that the independent doctor is supposed to be able to provide. Much depends, however, on the nature of the practice, how it is organized, and where it is located.

Dr. Judek's survey of doctors' attitudes to group practice is worth noting. He found (not surprisingly) that the vast majority of doctors already in group practice supported it. An almost equal volume of support was forthcoming from hospital doctors and medical teachers and researchers. Of the self-employed³² (the most interesting group from our point of view) half thought that it would not improve the *quality* of medical services, only a quarter thought it would not improve their *availability*, and only a tenth thought it would not improve *working conditions*. The length of time that the respondents had been in practice had little effect on their views on quality; but on the issues of working conditions and availability, the longer he had been in practice, the more likely the doctor was to say "no". In other words, the younger the doctor, the more likely he was to think that group practice improved the availability of medical services and improved working conditions; but those who opposed the notion that group practice improves quality were drawn equally from the ranks of the old and the young. There was less opposition on the quality issue from doctors in smaller communities (i.e., they were more likely to think group practice improved quality) but there was little significant difference between doctors from various sized communities on the issues of availability and working conditions.

We agree with Dr. Judek's judgement that "a group practice may prove to be an important method in planning the supply and distribution of medical care on a local and regional basis"; and that "general practice groups located in geographically strategic communities would ensure more equal distribution of medical manpower between rural and urban areas, and meet a major part of the medical needs of the average patient".

Method of Payment

It would be unrealistic to omit a reference, however brief, to the effects on medical practice of the fee-for-service principle: the more so since the OMA is officially wedded to it as the only tolerable form of reimbursement.³³

The main arguments urged in its favour are that it keeps intact the doctor-patient relationship, and that it is preferable to other methods in the degree to which it allows the consumer of medical services freedom of choice. On the first point, evidence from many countries indicates that public satisfaction or dissatisfaction (at least as measured by opinion surveys) varies little with the type of payment system. Every method of paying doctors has its peculiar disadvantages,

³²Nearly 5,000 self-employed doctors responded.

³³Moreover, the recent CMA survey indicates that 68 per cent of all doctors in Canada work on a fee-for-service basis.

but there is little to support the view that the doctor-patient relationship is better in France (for example), where a rather pure form of the fee-for-service principle operates, than in Britain where doctors are paid on a capitation basis.

The "free choice" argument is complex, and we must treat it summarily.³⁴ One of the best known restatements of the classical position is that of Professor D. S. Lees, whose pamphlet *Health Through Choice*, published in the early 1960's, created something of an international stir in the medical profession. Essentially, the issue turns on the old liberal economic argument that medical care is no different from the generality of market commodities.

Presumably (says Professor Lees) we can dismiss at once the view that medical care is a necessity of life; food, clothing and shelter are even more fundamental to human existence and they are supplied satisfactorily through the market.

This, of course, is true — except for about two-thirds of the world's population, some of whom live in our own society. Men *can* do without proper medical care (they have done for thousands of years), just as it is possible to live on a handful of rice a day in a shack made from cardboard and old tins.

Again, says Professor Lees:

. . . it is true that the incidence of individual ill-health is unpredictable and often very costly. But the same is true of fire risk, motor car damages, losses at sea and in the air and so on and, as is well-known, the problem is met through private insurance.

The short answer to this, I suppose, is to ask Professor Lees how many times a man's house burns down during the course of his lifetime. Medical insurance schemes are, in a sense, misnamed: they are mutual benefit funds. The chances that I shall require the services of a doctor for myself or my family in the next twelve months are somewhat greater than the risk that I shall lose my baggage in a collision at sea,³⁵ and the consequences of my not being able to afford him are likely to trouble me more than the thought of having to replace my trousers.

A further point (Professor Lees continues)

. . . is that people are not well-informed about ill-health and are thus unable to evaluate their demands for medical care in a rational way . . . (but) we are increasingly in the hands of the expert with regard to cars, washing machines . . . etc.

This is a matter of priorities. The results of neglecting health, one would have thought, are somewhat more important than getting the television repaired properly.

³⁴Reference was made to it in Chapter 1.

³⁵In 1961 Dr. Kerr White estimated that, within an average month, for every 1,000 adults, 750 would become ill or injured; of these, 250 would consult a physician, nine would be admitted to hospital, five would see a specialist, and one would be referred to a university teaching hospital.

On empirical grounds (says Professor Lees) . . . there are good reasons for supposing that individuals, if left to their own free choice, would have spent more on medical services than public authorities have done (this is referring, of course, to Britain).

On the contrary, such empirical evidence as we have seems to point the other way. For example, in one study of patients in France (where the patient has to pay the doctor in full when he arrives for a consultation and then claims a refund — now about 70 per cent — from the State) 39 per cent of the people interviewed said that, at one time or another, they had been unable to consult their doctor or had had to postpone their visit for lack of money; and it was found that the more children there were in the family, the less the recourse to medical care.³⁶

In brief, there are few good reasons for agreeing with Professor Lees' contention that: "medical care (has) no characteristics which differentiate it sharply from other goods on the market . . ." or for accepting his assessment of medical care as "a personal consumption good, and as such . . . a dubious candidate for collective provision".

The assumption on which the medical profession of Ontario bases its demand for payment-for-service, and more specifically, direct billing of the patient, is that this is the only means by which the profession can secure the right to deal with the patient in an unregulated and unfettered manner. There are grounds for believing that this is an impossible ideal. In theory, in a cash benefits or direct billing scheme (as Professor Glaser points out³⁷) the public authorities have a direct relationship with the insured patient only, not with the individual doctor: the fund is supposed to be reimbursing the patient, not paying the doctor; thus the relationship between doctor and patient is assumed to be exactly the same as it would be in purely private practice. Experience in all countries that have used this method indicates, however, that it is utopian to believe that the patient's relations with the doctor can be kept indefinitely in a completely unregulated market when his relations with the source of money have become a regulated public transaction. In the end, it seems, the cash benefit system differs little in its essence from the service benefits method, in which the patient receives the service and the doctor is paid by the public agency.

Without wishing to imply that one method of payment is necessarily superior to another, still less that other methods are without serious defects, the following are among the observed consequences of fee-for-service schemes.³⁸

- 1) Unnecessary, and unnecessarily prolonged, treatment may be given in order to boost the physician's income (particularly where the

³⁶Quoted in Gertrude Willoughby, "Doctors and Patients in France", *New Society*, December 22, 1966, p. 941.

³⁷William Glaser, *op. cit.*

³⁸What follows is based on material in Professor Glaser's forthcoming book, *ibid.*

fees are fixed too low). The danger is not so much underperformance as excess — but excess in the wrong directions.

- 2) Insuring agencies, concerned to keep down the cost of premiums, will employ audit procedures to detect and penalize unjustified charges. This adds to the overhead costs of the scheme, which may be greater than in schemes based on other methods of payment — for example, salary, capitation. Alternatively, the profession must attempt to police itself, with increasingly repressive measures, making disciplinary examples of doctors selected more or less at random.
- 3) There may well be pressure on the doctor to see an excessive number of patients per day, to give them sketchy attention, and to cut down on time-consuming home visits as against office examinations.
- 4) There may also be unnecessary referrals, particularly for diagnostic procedures such as x-rays and laboratory tests, and excessive referral to emergency departments of hospitals for time-consuming procedures that the doctor wishes to avoid.
- 5) There may be difficulties about what is to be included in the fee schedule (which becomes, in any case, more and more complex as times goes on):³⁹ for example, it is hard to itemize preventive medical procedures, relatively easy to itemize purely mechanical procedures that use standard equipment.
- 6) The fee schedule may be used as a weapon to outlaw procedures the medical Establishment suspects, and particularly against “medico-scientific charlatanism” — i.e., “fringe” medicine.
- 7) The fee schedule may distort the development of the various specialties: fee-for-service tends to benefit surgical specialties, for example, since their procedures are more easily itemized and priced.

These difficulties all tend to pull the matter of fees into the public arena: the insuring agencies must rely heavily on the goodwill of the profession, but at the same time the public demands that the defects of the system be ironed out. Regular consultation between the medical associations and public agencies becomes essential to morale and peace.

It should be stressed again that we are not suggesting that these consequences are necessarily to be found in Ontario. This can be decided only on the basis of empirical evidence, which is lacking at present. They have, however, been found to apply to a greater or lesser degree in all countries that have had experience of

³⁹The Ontario fee schedule has grown from 600 items in 1946 to 2,000 items twenty years later.

fee-for-service insurance in the past. Nor are we suggesting that there is a necessary causal connection in every case between fee-for-service and the phenomena described. On the contrary, there are almost always other factors at work as well.

Manpower Requirements

We now return, briefly, to the overall manpower problem. With the due caution that we urged at the beginning of this chapter, we can compare the current overall doctor-population ratio in Ontario of about 1:750 and the ratio in 1962 of 1:774 with the following comparative table derived from figures published in 1964 by the World Health Organization.

Australia	1:880 (1962)
Austria	1:550 (1962)
Belgium	1:720 (1962)
Denmark	1:810 (1960)
France	1:910 (1961)
Germany (Federal Republic)	1:670 (1962)
Italy	1:610 (1961)
Netherlands	1:890 (1961)
New Zealand	1:690 (1962)
Norway	1:830 (1961)
Sweden	1:1,000 (1961) ⁴⁰
U.S.A.	1:760 (1962)
U.S.S.R.	1:500 (1962)
United Kingdom	1:910 (1961)

The usual reservations must be entered in comparing these figures. Geographical and social conditions affect the number of doctors needed; the definition of "a doctor" varies between countries; and the bases of computation may be at variance.

We may summarize:

- 1) Ontario compares rather favourably in doctor-population ratio (for what this is worth) with Canada as a whole and with many countries of the Western world, including the United States.
- 2) But since the population of the province continues to increase and the demand for medical services with it (irrespective of policy decisions about the introduction of medicare), more doctors will be needed simply to maintain this favourable ratio.

⁴⁰Sweden is generally acknowledged to have one of the best medical services in the world.

- 3) Equally basic and pressing problems are the maldistribution of doctors as between specialties, as between specialization and general practice, and as between areas of the province.
- 4) Though the supply of doctors trained in Ontario and who remain to practise in Ontario will increase, continued heavy reliance will have to be placed on immigrant doctors.
- 5) The supply of immigrant doctors is uncertain. Though the effects of improvements recently recommended in the British health services will take some time to make themselves felt,⁴¹ there may well be a continued downswing in the supply of British doctors.
- 6) It would appear to be unwise, on the face of the available statistics, to place much trust in the immigrant doctor as a solution to the rural shortage in Ontario.
- 7) It is by no means certain that the domestic "pool" of potential recruits to the medical profession in Ontario has been fully tapped: easing the financial burden on the medical student may provide part of the answer, but not the whole of it. With this in mind, medical school recruitment practices and professional association public relations generally, and in the high schools, may repay careful re-examination.
- 8) The effort that the Ontario licensing authority is currently making in conjunction with its fellow licensing authorities in the other provinces, to standardize (and, it is to be hoped, liberalize) licensing requirements for immigrant doctors is likely to have some beneficial effect on the supply situation; but it would be unwise to expect it to effect a radical, and still less an immediately radical, improvement.⁴²
- 9) Quite as important as licensing are the twin issues of improving the use and the efficiency of existing medical manpower. It can, indeed, be argued that this is likely to be far more important in the long run than measures to increase the supply of home-trained and immigrant doctors.

Women in the Profession

There is evidence to suggest that many well-qualified girls fail to gain admission and that still more, although interested in medicine are discouraged from applying. The Departments have no doubt that, in common with many other countries, we will be unable to obtain all the doctors we need in numbers and quality unless considerably more women enter medicine. The situation will not be helped therefore by continuing to restrict their

⁴¹Moreover, as we have noted, dissatisfaction with the National Health Service is by no means the most important of the factors that have attracted British doctors to Canada.

⁴²This is not to say that "supply" is the only reason for "liberalizing" licensing requirements; quite the reverse — and we so argued in Chapter 8.

entry. It can be helped by changing those arrangements in the pattern of medical care, in the structure of post-graduate training, and in the system of part-time employment which at present contribute to the limited service rendered by women doctors.

Thus said the English Ministry of Health and the Department of Health for Scotland in their joint evidence to the Royal Commission on Medical Education. Much the same might be said of the situation in respect to women doctors in Canada.

Statistics on employment and other aspects of the status of women in the medical profession in Canada are not always consistent; but the source most commonly quoted is the study made by Dr. Eva MacDonald and Miss E. Webb of the CMA which was published in 1964.⁴³ This showed a total of just over 1,700 women doctors in Canada.⁴⁴ Just over half of these were in full-time work and another 6 per cent were in part-time work. Together with 18 per cent in training, this gave a total of some 80 per cent working and 73 per cent working full-time. The rest were "retired", "not in practice", or did not say what they were doing. From private information,⁴⁵ we have reason to believe that the proportions in Ontario did not differ much from the national picture. About 37 per cent of all working women doctors in Canada are certified specialists (a little higher than the proportion of men).

In 1964, 38.6 per cent of women doctors were in private practice (probably a little higher in Ontario), 15 per cent were interning or residents (about the same), 10 per cent were on the staffs of hospitals (the same), 3 per cent were in full-time teaching (the same), nearly 12 per cent were in preventive medicine (the same). The proportion of women doctors interning and in residence was about the same as that of the total physician population; there was a somewhat higher proportion of women in hospitals; nearly twice as great a proportion in teaching; a greater proportion (three percentage points more) in preventive medicine; a much smaller proportion in private practice; and, of course, a far greater proportion retired or not in practice. The proportion of women doctors in anaesthesiology was greater than the proportion of men doctors, in general practice substantially less (27 per cent), in internal medicine less, in surgery (naturally) much less (1.2 per cent to 13.5 per cent); but in pathology, radiology, psychiatry and neurology more; in obstetrics and gynaecology about the same; in paediatrics more (6.2 per cent to 2.6 per cent); and in public health more than six times as many, proportionately.

⁴³E. M. MacDonald and E. M. Webb, "A Survey of Women Physicians in Canada, 1883-1964", *Canadian Medical Association Journal*, Vol. 94, p. 1223.

⁴⁴Actually, 2,191 women doctors were listed: 76 of these were found to have died, and 216 were abroad, leaving 1,899; it was not possible to trace 146, which reduces the total to 1,753.

⁴⁵Interviews with members of the Federation of Medical Women of Canada, on which much of this section is based.

A study of 104 women graduates from the University of Western Ontario⁴⁶ (the University graduated its first woman doctor in 1924), published in 1966, showed that all of those graduating after 1959 were still in medical work: six were employed full-time, one was employed part-time, and the other thirteen were still in training. Of the remaining eighty-four (those who graduated before 1959) 65.5 per cent were in full-time medical work, 19 per cent were in part-time work and 15.5 per cent were not working in medicine. There were 48 per cent in private practice, 34 per cent in "non-academic salaried work", 11 per cent combined the two and about 4 per cent were in academic work. Of the women then doing medical work and married to doctors, about a third shared a practice with their husbands. General practice, psychiatry and preventive medicine were the leading categories of work. Fewer of the women who had borne children were currently engaged in medical work than were either single or childless married women, and child-bearing was the most important determinant of whether the woman doctor was working or not. The husband's occupation was found to be irrelevant in this respect.

Another study, by Dr. Marilyn Trenholme,⁴⁷ adds to our picture. This was a study of a group of women doctors in family practice (176 in all). Two-thirds of them were full-time family doctors, 30 per cent were part-time, and 4 per cent were irregularly engaged in family practice. All the single doctors were full-time, 58 per cent of the married doctors were full-time, and a third of the full-time group undertook some other kind of medical work in addition to their practice (public health, industrial medicine, teaching and research, anaesthesia, university health service, and so on). Women patients were in the majority in most instances, and over half the doctors reported that their practice was 90 per cent or more female. Infants constituted 10 per cent or less of their patients, though children from one to sixteen years constituted between a tenth and a quarter. Two-thirds said they made no deliberate attempt to exclude or limit any particular class of patient, but about a fifth did specifically exclude men. Of their areas of particular interest in medicine, 45 per cent listed gynaecology, 42 per cent obstetrics, 42 per cent paediatrics and 39 per cent "emotional problems". Many said they were "eagerly accepted by women patients", particularly by teenage girls and older women; but a few said "women who want authoritarian doctors prefer males", "some women prefer men, that's natural", and "some of them (i.e., women patients) don't trust lady doctors". They thought "children seem to be less afraid of women doctors"; they felt that women patients think they get greater understanding and "empathy" from women doctors, and that women appreciate the chance to discuss problems they could never discuss with a man. On the male

⁴⁶Carol Buck, Mary Scofield and O. H. Warwick, "A Survey of Women Graduates from a Canadian Medical School", *Canadian Medical Association Journal*, Vol. 94, April 2, 1966, p. 712.

⁴⁷Marilyn Trenholme, "Woman Doctors in Family Practice", *Canadian Family Physician*, September 1967, p. 45.

patient question: "Some male patients are embarrassed . . . labouring classes (sic) and most of the professional class don't mind; middle class men may resent being put in a position of inferiority."⁴⁸

Why don't more women enter the medical profession? And why don't more women doctors work? The answer to the first question lies partly, as we have seen, in the admission practices of the medical schools and in a certain discriminatory attitude on the part of the male profession and its collective organizations, including the hospitals. If one asks why these practices and these attitudes exist, the reason lies, at least in large measure, in the answers to the second question.

Married women doctors living with their husbands must obviously go where their husbands work, and sometimes there is no room for them to practise medicine in that locality. They may even be licensed in one province but have moved to another where their license is not accepted. Some women doctors are unwilling to work because of their husband's career or the children; and, in any event, the employment of domestic help is not an allowable expense against tax. Women doctors may feel inadequate after a period of absence from practice. This could be remedied by refresher courses. The Federation of Medical Women has been pressing for these and the Toronto branch has recently set up a preceptorship scheme. This applies to G.P.'s, and a limit of ten years away from practice has been set. The Ontario Department of Health is paying the cost of the course, which is run by the University Division of Postgraduate Medical Education, headed by Dr. Ian Macdonald, a former President of the Ontario College of Physicians and Surgeons. The first course was held during three weeks in February 1968. Questionnaires sent to more than 100 inactive women physicians in Ontario evoked an expression of interest from forty women. Twenty-seven ultimately participated in the course.⁴⁹ (Some of the participants were "foreign doctors who had not got their Councils", i.e. had not passed the MCC examination — one or two wrote these examinations after taking the course.)

Two possible answers to the problem have already been suggested. It must be made financially worthwhile for the woman doctor to return to work (at least, the combined family income should not have to suffer if she does);⁵⁰ arrangements must be made for the care of children (not necessarily a housekeeper: creches and nursery schools for the preschool children of young women doctors established within the hospitals have been suggested). Refresher courses are essential in many

⁴⁸It would be nice to think that this is why 75 per cent of the doctors in the U.S.S.R. are women. Unfortunately, though the Soviet Union is composed, as is well known, exclusively of workers and intellectuals, the real reason is social: that medicine is regarded as women's work in Russia and also, partly, that there were heavy losses of doctors during the Great Patriotic War against Germany.

⁴⁹Experience with the course is summarized in Dr. J. O. Godden, "Operation Recall: The 'Rehabilitation' of Inactive Women Physicians", *The Medical Graduate*, Spring, 1968.

⁵⁰We should not think of income-tax exemptions purely in terms of the non-working woman doctor, however; they might also encourage some part-timers to work full time.

instances and perhaps in most. Many women doctors (who may already be married when they qualify) leave shortly after interning, and they are lacking in experience; other experienced but older women are "rusty".

But there are other issues too. There is, it is true, a certain inevitable rigidity in the hospital system which makes it hard to fit in the part-time physician; but hard-pressed emergency and out-patient departments could certainly use part-time help. As Dr. Roberts argues:

A well-trained woman (or several part-time women) staffing an out-patient or emergency department in a hospital could give a far better service than the present casual resident service offered which has often little interest and no continuity.⁵¹

The spread of group practice, too, should make it easier to accommodate the part-time woman doctor; and women could be used (provided proper administrative arrangements were made) in a "relief" capacity, even in general practice. Lastly, there is a wide range of medical practice which is at present undermanned that could well absorb women doctors on a part-time basis: work with geriatric patients, for example, and work with the mentally retarded, in family planning, and in marital counselling and sex education.

It is not to be expected that efforts to encourage the employment of women doctors will make more than a token contribution to the immediate manpower situation; but it is surely folly, in modern conditions, when so much part-time work in other occupations is done by women, to waste even those resources that we have. Moreover, the knowledge that there exist greater and more rewarding opportunities for the married woman doctor, with adequate "refresher" training for her when her children are old enough to allow her to return and sufficient financial incentives to make such a return worthwhile, might well encourage more young women to enter the profession in the first place.

⁵¹These words are borrowed from Dr. Maureen Roberts' provocative and good-humoured address to the CMA Centennial Conference on Medical Manpower, June 1967. Dr. Roberts is an official of the Federation of Medical Women of Canada.

Chapter 14 Medical Research

*We must approach this matter in a different way;
it is great and mystical: it is no common thing;
nor given to every man.*

—Epictetus the Stoic, 1st century A.D.

The title of this chapter is misleading, for it is not part of the author's terms of reference, nor those of the Committee on the Healing Arts, to inquire into the state of medical research as such. Some reference must be made to it, however, because of its close connection with teaching in medical schools.

As Paul Ferris puts it:

When half the present-day consultants were medical students, they might have read, in one of the standard pre-war text-books, that in cases of bronchitis, "if possible the patient should winter abroad, in Europe or North Africa". Under "lobar pneumonia" they would have learnt that "Hippocrates noted that the crisis frequently occurred on an odd-numbered day"¹

Clearly this will no longer do. Today's new orthodoxy is that "the role of research in scientific education is of basic importance"² and that "research is today an absolutely essential element in the preparation of young doctors and in the continuing education of established physicians".³

Drs. Laidlaw and Mustard, two of the men most actively concerned in the creation of the Canadian Association for the Advancement of the Health Sciences, have argued that:

Real progress in this area requires first that the idea that research is a luxury should be laid to rest. Without substantial investments of men and money in medical research, a high quality of undergraduate education, and hence a high standard of health care cannot be achieved. Furthermore, the accurate assessment and the prompt diffusion of new discoveries depend upon a core of teacher-scientists kept actively engaged at the frontiers of human knowledge.⁴

¹Paul Ferris, *op. cit.*, p. 92.

²*Medical Research in Canada: an Analysis of Immediate and Future Needs* (The "Gundy" Report), mimeo, December 1965.

³R. S. Morison, "Clinical Research in the Community", *Canadian Medical Association Journal*, Vol. 90, 1964, p. 335.

⁴J. F. Mustard, J. C. Laidlaw and J. O. Godden, "Medical Education and Research: The Foundations of Quality Health Care", *Canadian Medical Association Journal*, Vol. 94, 1966, p. 795.

It may be that talk of "frontiers" is becoming a little overdone in contemporary academic circles: the fact remains that there is a great deal of "bread-and-butter" research to be done, of a fairly strictly applied kind, and in this particularly Canada cannot afford to fall behind.

The importance of research is seldom disputed. And although there is room for argument about priorities, and particularly about the proportion of national and provincial resources that can be devoted to the promotion of health science research, nobody seriously rejects the four major points made by the Gundy Report: that modern medical education and medical research are interlocking and virtually inseparable functions (the teacher-scientist is an essential component of the modern medical school); that these men cannot be attracted and held unless a favourable research environment is created; that this favourable environment depends on adequate capital and operating funds being made available; and that the crisis problem, that of attracting and keeping an adequate stock of teacher-scientists, calls for immediate action.

There are certain unique features about the Canadian situation. In the past, medical research in Canada has suffered from serious neglect. It is said that when Banting was asked to accept an appointment on the National Research Council in 1935, he did so on the understanding that research in medicine would receive serious attention by that body. It was due largely to his advocacy that, in 1938, an Associate Committee on Medical Research was set up in the NRC with himself as chairman and Dr. Wilder Penfield as one of the members. It was Banting, too, who initiated the first survey of research facilities in Canadian medical schools, the latest of which is at present being undertaken by the Medical Research Council.⁵

In 1946 the NRC set up a Division of Medical Research. Two years later a second survey of medical research needs was begun. Pressure for greater support for medical research increased, and in 1958 the government set up a special committee "to review the procedure by which the Government of Canada supports research outside its own installations. . . ." One of the major recommendations of this committee (the Farquharson Committee) was that a Medical Research Council should be created. This was done in 1960, by a Cabinet directive to the NRC. It was established as a virtually autonomous body, independent in its policy-making, but under the general administrative aegis of the NRC. The present Chairman of the Medical Research Council, Dr. Malcolm Brown, recently told the Senate Committee on Science Policy that:

. . . the Council is anxious now, and hopes to proceed as quickly as possible, to obtain legislation so that . . . the umbilical cord of the NRC, which has been so helpful over the years, (is) finally cut . . . (this has now been done).⁶

⁵As is well known, Banting died, in fact, in furthering medical science: for he was on a trip to England in 1941 when the bomber in which he was travelling crashed on landing. To say that medical research in Canada has suffered from neglect is in no way to denigrate the work of a number of brilliant men and at least one woman (Maude Abbott).

⁶Senate of Canada, Proceedings of the Special Committee on Science Policy, No. 8, March 21, 1968.

Earlier, he had told the Committee on the Healing Arts that:

The present arrangement is curious . . . we are cocoons The final authority . . . administratively speaking is the National Research Council, but this is a paper device to quite an extent It is a very curious arrangement which so far has not worked too badly.⁷

Since 1960 the responsibilities of the MRC have been very much increased. At one time, most of its interests lay in the basic sciences:

. . . and there was not perhaps the same interest in clinical research and the applied research side of medicine. That has changed now: the entire spectrum of medical research from its most basic aspects through to what happens at the bedside is now the interest and responsibility of the MRC.⁸

Its budget has grown from 2.3 million dollars in 1960 to 27 million in 1968-1969.

In this time it has become the main arm of the Federal Government in the support of medical research. It has become the main channel through which the Federal Government transfers money from itself to researchers in universities and their associated hospitals. In 1968/69 it will be responsible for about 75% of this transfer.⁹

The pattern of medical research in Canada is unique in one important respect: the MRC (unlike its counterpart in the U.K., for example) does not conduct research itself, in its own laboratories. But it is different in other respects too. Most of the research (apart from that done in a purely developmental context by the drug houses) is done in medical schools and universities and in their hospitals. Some is done in government laboratories, but much less than in the U.K., and some in research institutes — though there are few of these compared with the U.K., the U.S. or France,

At the present time there are about 1,500 researchers in charge of projects and directing research in the medical schools; about sixty more in the schools of pharmacy; and a few hundred more in government laboratories and industry.

These people have various backgrounds. Many of them, but not all of them by any means have an M.D. degree. Some have the D.D.S. or D.V.M. degree. Many, of course, have a Ph.D. degree, and this group includes those who do and those who do not have an M.D. degree.¹⁰

An MRC survey found that in 1965-1966 there were 1,513 investigators active in research in the medical sciences in Canada: 52 per cent of them were full-time, with a further 18 per cent "geographic full-time", and 30 per cent part-time or having no appointment. Sixty-one per cent of the time of the full-time "teacher-

⁷Private hearings November 14, 1967.

⁸Senate Committee Hearings, *op. cit.*

⁹*Ibid.*

¹⁰*Ibid.*

scientists" was devoted to research; 31 per cent of the time of the geographic full-time and part-time staff was so occupied.¹¹

The following breakdown of research activity by type is of interest:

	Percentage of investigators	Percentage of time devoted to research
Basic sciences	29	64
Paraclinical sciences	16	50
Medicine and medical specialties	32	43
Surgery and surgical specialties	19	28
Other	4	52

Forty-three per cent of the investigators used no professional assistants and had no trainees, 25 per cent used no technicians, 16 per cent used no supporting staff. Forty-seven per cent used less than three supporting staff. In other words, investigators with few or no supporting staff formed a significant proportion of the whole: an indication of the relatively small scale on which research is being carried on. It is particularly notable that such a high proportion of researchers are "lone wolves" and are contributing nothing to the training of their successors. Thus, although it appears the Gundy Report slightly overstated the number of full-time investigators and understated the amount of time they were devoting to research, it was right to call for much greater support for research by full-time staff, *with larger teams*.¹²

Aside from the MRC funds, federal money for university-based medical research comes mainly from the Department of National Health and Welfare, the Defence Research Board, and the Department of Veterans' Affairs. In 1968-1969 these agencies are expected to add another 5.25 million dollars to the 27 million provided by MRC. This is, of course, for research promotion. Federal support for capital investment in laboratories and so on comes from the Health Resources Fund, with matching grants from the province. Some money for operating costs comes in grants and in other forms from voluntary health agencies. Foreign sources of finance (mainly American, such as the National Institutes of Health) are shrinking.

This suggests a further important difference between the Canadian situation and that in some other countries. In Canada the investigators' salaries come almost entirely from university funds; but in the United States, for example, more scientists are paid from outside grants than from university sources. This outside subsidization has results that are not always fortunate for academic ad-

¹¹Compare data on p. 207 of Chapter 12, dealing mainly with British-origin medical faculty. The bases of computation appear to have been somewhat different.

¹²The data quoted in the above section are drawn from MRC Report No. 1—Survey of Research Personnel in the Medical Sciences in Canada, 1965-66. Published by the Medical Research Council.

ministration or, for that matter, for the conduct of research. Operating costs in Canada, on the other hand, are different again.

The costs that remain after the building is paid for and in operation and after the scientist has received his salary — the costs for graduate students, technicians, post-doctoral fellows, supplies and equipment, all these operating costs — come almost entirely . . . from extramural sources. (In the U.K.) about one-third of such costs are paid from university sources. It is nothing like a third in Canada; it is probably much less than 10%.¹³

Of the current 27 million dollars of MRC money, about 70 per cent is spent on grants-in-aid, 25 per cent on support of people in training, and about 5 per cent on research promotion and development.¹⁴ On the promotional side, it is interesting to note that the Council is currently planning to sponsor the production of the antilymphocyte serum which is vital in transplant surgery. There was, at the time of writing, no available source of supply, either in Canada, the U.K. or the United States.

As was stated earlier, the MRC, unlike some of its counterparts in other countries, has no laboratories of its own. However: "the desirability and feasibility of these is now being explored." In particular, "one possibility being actively explored is that of drug research institutes . . . under aegis and sponsorship of the Council". Of the money going in grants, about 35 per cent is in support of research in clinical departments, as against basic science laboratory work. This has been a neglected area. As Dr. Brown puts it:

It is a fact that laboratory research has a cachet or glamour that has diverted people from other types of research which are necessary and can be very productive . . . the encouragement (of clinical research) is something that concerns us . . . the cure for the situation (however) will lie in the arrangement of circumstances for those doing clinical work so that they can do good research at the bedside (i.e., in a rearrangement of "medical time").¹⁵

Turning briefly to the situation in Ontario: in 1965-1966 Queen's University Medical Faculty received just under one million dollars for research from outside agencies. These, apart from the MRC, included the NRC, the Department of National Health and Welfare, the Ontario Department of University Affairs, the Defence Research Board, and the World Health Organization; several drug companies including Pfizer and Ciba; Ford of Canada; and voluntary health agencies such as the Ontario Heart Foundation, the Canadian Heart Foundation, the National Cancer Institute, the Muscular Dystrophy Association, the Ontario Cancer Treatment and Research Foundation, and the Ontario Mental Health Foundation. Individual investigators may, of course, be sponsored by

¹³Senate Committee Hearings, *op. cit.*

¹⁴Much of this money is directed to the promotion of research in the new medical schools such as McMaster.

¹⁵Senate Committee Hearings, *op. cit.* Words in parentheses added.

several agencies. Of the projects under way in 1966-1967, one investigator, for example, was sponsored by the MRC, the Defense Research Board, the Canadian Life Insurance Officers Association and the Wellcome Trust; another's projects were variously sponsored by MRC, National Cancer Institute and the Canadian Life Insurance Officers Association.

In the same year, the University of Toronto received just over 3 million dollars for medical research from outside agencies. More than 1.25 million of this came from the MRC. Only \$25,000 came from the U.S. government agencies, although there was a large grant from the Commonwealth Foundation. Similar details are not available for the University of Western Ontario, but projects in hand in 1966-1967 were supported by the Defence Research Board, the Department of Veterans' Affairs, the Department of National Health and Welfare, MRC, National Cancer Institute, the Muscular Dystrophy Association, the Canadian Tuberculosis Association and others.

Part of the task of creating an attractive "research environment" is to provide a sense of security — at least in the short term — for the potential researcher the university is hoping to attract. This is one of the aims of the MRC's Negotiated Development Grants. Under this scheme, the MRC uses part of its funds to facilitate the development of research in areas not previously covered, or only sketchily covered, in the institutions concerned. Medical schools are thus assured of the support necessary to enable them to make fairly substantial commitments to the scientists they are seeking to recruit (these men will usually insist on certain guarantees before they will accept a post). Such a grant has been made to McMaster to assist in its recruiting commitments.

Speaking at the opening of the Clinical Research Institute of Montreal in April 1967, Dr. Malcolm Brown said that the clinical research picture can be criticized. Because many clinical investigators have to devote a great part of their time to administration, they sometimes do not finish the work they begin. Sometimes they spread themselves too thinly; others choose the wrong problems, problems that require a depth of basic scientific knowledge that they do not possess. "It is wasteful to see a clinician using a basic scientist as an assistant and frightening to see a basic scientist using the clinician as an assistant." The most unusual and valuable people in medical research are the people who can combine the knowledge and personality traits of both. Dr. John Evans has put a related point:

When the . . . accreditation agencies look at these schools, their principal criticism is lack of suitably-trained scientific staff. These schools have depended to a large measure on people who have given their time on a voluntary basis and on people who have survived from the war period. They were good teachers but they had very little opportunity to participate in research These people have done their very best but they haven't got the same role (sic) to offer now. So the accreditation commission looks at a school and says that you have no one who is familiar

with modern genetics teaching your medical students — that you have an old bacteriologist but no modern micro-biologists. Where are the immunologists and so on? What we have to do is to reverse the deficit that exists now. Sure, we have to double the staff. But what is the calibre of the 1,000 or 1,100 people we have now? We all agree that these people have done a wonderful job with what they had available, but many of them have to be updated or compensated for¹⁶

Much of the pressure that has been created in recent years respecting medical research has been devoted to attempts to persuade governments, and in particular the federal government, to provide more money. Less attention, perhaps, has been given to questions of better planning and the creation of appropriate machinery for directing the overall research effort at the national and provincial levels. It is, one hopes, significant that the Ontario Council of Health has established a research committee under the chairmanship of Dr. Fraser Mustard, one of the initiators of the Gundy Report, with "Gundy" adherents among the medical research scientists prominent on its various subcommittees. In spite of its title (the Health Research Committee) almost all the members of the main committee and its subcommittees are doctors. It is to be hoped, too, that the Ontario Council of Health will fill another gap. A recent Commission on Medical Research (the Whittaker Commission) set up by the American Medical Association commented:

The research projects that will have the most important effects on medical service, certainly in the immediate future (that is, on medical service *outside of medical education*) are those relating to the *development of new methods in the provision of health care and the administration of the health services*. These projects involve the study of the roles of different members of the health care team, the economics of health care, the role of the medical centre in the health care complex, and the coordination and regionalization of health care services.¹⁷

Nobody doubts the impact of *research in medicine* on medical education and medical practice. We should not forget, however, the almost equal importance of *research on medicine* — research relating to medicine as a vital human activity — for both these areas, but particularly for the latter: medical practice. It should be emphasized that the distinction is not between medical research carried out by medical scientists and research on medicine carried out by social scientists, for the medical scientist is urgently required for the latter as well. But the general principle is clear: progress in health care depends not only on better medical research but also on a better understanding of the nature and practice of medicine itself.

¹⁶Toronto *Globe and Mail*, Weekend Magazine, September 24, 1966.

¹⁷Emphasis and words in parentheses added.

Part Five: The Medical Profession, the Government, and the Related Health Professions

Chapter 15 Relations With Other Professions and Groups

Between us and you there is a great gulf fixed.

—*St. Luke, 16, xxvi*

We shall treat this topic summarily because it is covered extensively in other reports to the Committee. It is too important, however, to be dismissed entirely here.

General Attitudes

"Occupations undergoing professionalization," say Vollmer and Mills,

. . . are often dependent on more highly professionalized occupations and therefore tend to be on the defensive. With certain less professionalized occupations where there is an aspiration toward more highly professionalized status, the occupation may perforce engage in a struggle for survival. In this process, practitioners may expect at best to be avoided by related occupations unwilling to recognize their existence, because members of other occupations may feel that the newer work activities impinge on established occupations or that the calibre of the services provided by the new occupation is not "up to standard".¹

Again:

Sociologists have often observed that the emergence of a new profession is facilitated or retarded by the reactions members of older established professions have to the newcomer, and that these reactions are usually based on such factors as how these established professionals perceive the function of the new occupation and how threatened they feel their own interests to be.²

¹Howard Vollmer and Donald Mills (eds.), *Professionalization*, Prentice-Hall, Englewood Cliffs, 1966.

²Richard Kerckhoff, "Interest Group Reactions to the Profession of Marriage Counselling", *Sociology and Social Research*, Vol. 39, 1955, p. 179. Quoted in Vollmer and Mills, *op. cit.*

Thus we tend to find the medical profession acting paternally and sometimes protectively towards the hospital-based occupations of nursing and paramedicine; with disdain towards others, such as optometry; and with positive hostility towards some, such as chiropractic and naturopathy. On the side of the "rising groups" we find attitudes of extreme deference (from masseurs, for example, who are anxious to gain "respectability" in the public eye by getting doctors on their boards of governors and advisory committees); cautious, cool but essentially defensive postures, as in the case of dentists;³ and struggle-for-survival aggressiveness (for example, again, from chiropractors).

In one study of chiropractic in the United States the author says:

Chiropractors in general believe that the main reason they are persecuted is that their competition threatens the prestige and vested interests of the medical profession.⁴

This is probably nearer the truth than the allegation that the root cause is economic. As we saw in Chapter 2, Professor Dennis Lees (in his essay *The Economic Consequences of the Professions*) argues that the case of the British osteopaths illustrates "both the conservatism of the medical profession and its collective efforts to suppress substitutes for its own services". It is surely a very curious argument that says the selfish protectionism of the doctors has prevented the osteopaths from securing state registration so that they may protect themselves against unlicensed persons (i.e., practise selfish protectionism). The activities of pharmacists, osteopaths, chiropractors, herbalists, faith-healers and others, says Professor Lees, "all serve to increase the elasticity of demand for medical services". We have already indicated that we do not find this argument (that it is the economic interests of doctors that dictate their attitudes to drugless practitioners) very plausible. There may be an element of economic protectionism here (as the Editors of the *Yale Law Journal* have argued),⁵ but we suspect that the root causes lie elsewhere: in the training of doctors, in the inculcation of protective attitudes towards medicine as a specially skilled mystery, and perhaps (surprising though it may seem to some) in a genuine concern for the welfare of the patient. This concern may be, on occasion, muddle-headed or even misdirected, but it is not for that reason necessarily insincere.

It is important, moreover, to appreciate what the attitudes of organized medicine (at least in Ontario⁶) actually *are*. In the first place, those groups "whose

³There seems to be very little contact between organized medicine and organized dentistry in Ontario, except on a few crucial issues such as oral surgery, oral medicine and anaesthesia for dental surgery. One witness appearing before the Committee on the Healing Arts (the Registrar of the Royal College of Dental Surgeons of Ontario) told the Committee emphatically that "oral surgeons are dentists". This is denied by many doctors.

⁴W. I. Wardwell, "Strain in a Marginal Social Role", *American Journal of Sociology*, Vol. 61, 1955, p. 23.

⁵"The American Medical Association: Power, Purpose, and Politics in Organized Medicine", *Yale Law Journal*, Vol. 63, 1954, p. 938.

⁶The qualification is important, for there are significant differences in official attitude on the part of the profession from province to province.

members are required by legislation to practise only under medical supervision or upon referral (from) or prescription of a medical practitioner" (nurses, physiotherapists, radiological technicians, ophthalmic dispensers, and so on) — in other words, those who practise under some degree of medical paternalism, and economic and social dependency on the medical profession — are generally exempt from censure. They "present no problem from the standpoint of the College (of Physicians and Surgeons of Ontario) and it (had) no recommendations (for the Committee on the Healing Arts) with respect to education, regulation, or legislation pertaining to them".⁷ These are the professions which are described by the OMA as "intimately associated with our profession in their education, training and daily work".⁸

Those who practise independently of the medical profession, however, are more suspect. These include optometrists, chiropodists (or podiatrists), osteopaths, chiropractors and naturopaths. Masseurs were originally in the first group (at least insofar as they could practise only on the prescription of a medical practitioner) but are now, since 1955, in the second. But this group is not all of a piece. Physicians, says the OMA, have never held a monopoly on healing; indeed, they were themselves an offshoot from the priestly profession.

Historically, they have had to live with barbers, midwives, and bone-setters

What is our relation to (the host of -ists, -icians, and -ologists that have been added in the recent past)? There are those who practise independently, those who practise only in cooperation with medicine, those who work with or under the supervision of a physician.⁹

In other words, osteopaths are third-rate doctors, but at least they have some medical training. Chiropodists and masseurs often do work with, and under, doctors. Optometrists are bearable, as long as they stick to their last. Chiropractors ought to work only on prescription from a doctor. Naturopaths are beyond the pale. This, in brief, is the official edict.

Independence of the medical profession is therefore one factor in the equation, but it is by no means the only one. Most of these groups seek to extend their areas of competence, legal as well as actual, and claim to be qualified to enter into realms considered sacrosanct. Chiropodists (or podiatrists) want to perform "surgery of the foot"; optometrists wish to prescribe contact lenses and treat children for strabismus.

Before proceeding to look briefly at each of the disciplines, it is as well to note three of the six principles which the College has suggested should determine

⁷Briefs to the Committee on the Healing Arts.

⁸*Ibid.*

⁹Article in *Ontario Medical Review*, July 1966.

the practice rights of "disciplines licensed apart from the Medical Act".¹⁰ First, "practice should be based upon scientific principles, preferably taught in a university environment". There are two rather different issues here. In the first place, it is doubtful whether many of these disciplines really require university training. A seemingly respectable university curriculum can be manufactured for almost any trade; but it may not be in the public interest, or in the interests of the institutions concerned, for this to be done. Second, there will always be dispute about "scientific principles" and (unfortunately for its argument in the eyes of the public) the medical profession itself has not been blameless in this regard. Traditionally the profession has been extremely conservative in these matters, and its opponents can easily find examples of the tendency of doctors to confuse the "unscientific" with the merely unorthodox.

The second principle is that "those diagnosing human ailments should have a thorough understanding of the structure and function of the whole human body and the pathological conditions that may occur in any part of the body". How far, however, is this an ideal — even for the average doctor? One cannot really argue with the OMA when it contends that "the human body is a complex structure of many constituent parts and it is hazardous to deal with symptoms referable to one part without an understanding of the whole . . . (A) sound, accurate and valid differential diagnosis . . . requires breadth and depth of education and training in order to assess the possibilities inherent in the findings, to appreciate their implications, and to have an awareness of one's limitations to deal with them."¹¹ This is certainly a powerful argument for restraining the overweening ambitions of "ignorant pretenders to skill in medicine"; but it should not be pressed too hard or it will rebound on the head of the doctor who, like many in Dr. Clute's sample, is "obviously very conscientious but just (does) not know how to proceed in order to reach a diagnosis".¹² (Is it possible, Dr. Clute broods, "that some (doctors) are capable of the kind of mental activity that is necessary in the diagnosis of medical conditions, but that others, though of equal general intelligence, lack this particular facility . . .?") To this laudably honest question, experienced patients will answer "Yes.")

The third principle on which we wish to comment is that practice should not be "influenced or circumscribed by any preconceived philosophy of the nature or cause of disease". Again, one cannot argue with this as a general contention; but the medical profession, in asserting that it is not so influenced, is skating on very thin ice indeed. The whole history of medicine is riddled with examples of ferocious attacks by the medical establishment on scientific innovators, "imposters" whom

¹⁰The other three are: competence not to be determined by examination only; in assessing occupational training, not only sufficiency of curriculum but standards of staff, equipment, libraries, and so on to be considered; and a single standard of training to be established for all those "primarily responsible for the diagnosis and treatment of human ailments".

¹¹Brief to the Committee on the Healing Arts.

¹²K. F. Clute, *op. cit.*, p. 383.

later generations hailed as giants. We should be clear, however, about the argument: it is not that the medical profession does not change its "philosophy", because it does — though often very slowly; it is, rather, that its very cautiousness and refusal to accept anything but "received" doctrine leads numbers of patients to seek relief elsewhere.

Osteopaths and Chiropractors

Official opposition to osteopathy is not new. In response to pressure, in 1964, the College of Physicians and Surgeons made what it describes as "an extensive survey" of the education and training provided by the osteopathic colleges. All of these are American. The conclusion of the study was that the quality of the schools did not reach the standards of Canadian medical schools, and that the claim by the osteopaths that they do was false. There is no osteopathic school in Canada, and in face of official opposition from the profession, it is unlikely that there will be one in the foreseeable future. There are, in fact, only about fifty osteopaths now in Ontario, and it appears that very few have been registered in the past twenty years. The College says:

Although these schools today provide training superior to that of chiropractic schools, and although they no longer give prominence to osteopathic dogma, they remain substantially below . . . standard¹³

Ontario osteopaths are registered under the Drugless Practitioners Act, whereas in some provinces they come under the Medical Act. The trend in the United States, as the Hall Commission pointed out, is to incorporate into the regular practice of medicine osteopathic physicians who conform to the standard practice of medicine. Nevertheless, in thirty-nine of the United States and in the District of Columbia, the osteopath has full practice privileges. (About half of the American osteopaths work in small towns where the number of regular doctors is small, but according to Gross,¹⁴ there are fifty-seven in the Manhattan telephone directory.) In many of the states they have hospital privileges also; in Canada, however, they have none.

The osteopath is attacked by medical men on the ground that his practice is not based on scientific principles; and as Gross nicely puts it, "the language of osteopathic theory does ring exasperatingly vague to someone attuned to the semantics of conventional medical thought". At the same time, the man in the street may be excused a little bewilderment. Manipulation is (literally) as old as medicine itself (it was practised by Hippocrates); yet, as one Ontario doctor puts it:

Very little is taught in the medical schools about mechanical lesions of the spine or locomotor system, and nothing whatever about manipulation. The average doctor . . . confesses to complete lack of knowledge of the

¹³Brief to the Committee on the Healing Arts.

¹⁴Martin Gross, *op. cit.*

subject. Although there has been a wealth of . . . literature, there is only a handful of doctors in the whole of Canada adequately trained to practise manipulation with knowledge and skill.¹⁵

That the traditional approach of the profession is no longer accepted by many medical men is evidenced by the formation of the British Association of Manipulative Medicine in 1953, the holding of international congresses, and the formation in 1965 of the North American Academy of Manipulative Medicine.

Dr. Thomas continues:

Almost every (sic) general practitioner has felt that orthopaedic medicine should be practised by the medical profession, yet for many years it has been most embarrassing to find that our patients drift off to lay manipulators where sometimes they experience rather spectacular cures, much to the embarrassment of organized medicine . . . but one must be aware of the dangers to the patients and to the future progress of medical manipulation, of manoeuvres inadequately learned (sic), indiscriminately applied and clumsily performed.¹⁶

Nevertheless:

Many of the world's nations are surpassing us in manipulative medicine. This situation demands a remedy and presents a new challenge to Canadian doctors.¹⁷

The argument of the chiropractors is that many doctors actually approve of what they are doing, but are impotent in the face of official opposition and the hostility of the drug houses. While medicine pretends to regard chiropractic as pure quackery, at the same time it is incorporating chiropractic principles and techniques into its own practice, though under disguised names ("physical medicine", "manipulative medicine", "physiatry" and the like).¹⁸ Wardwell comments: "There is just enough basis in fact for the belief that a medical monopoly exists and that organized medicine is principally responsible for the legal restrictions on chiropractors to permit the ideology to function in this way."

One orthopaedic surgeon to whom we talked said that "the trouble with chiropractors is that they attempt to extend a method that works well with specific conditions to a whole system and philosophy of healing for all conditions. While manipulation is certainly a valid form of treatment for certain complaints, it is no cure for diabetes . . . (Its) use in certain cases instead of orthodox medicine has led to harmful effects, allowing diseases to spread." Most doctors to whom we mentioned chiropractic produced their favourite case, usually (if one may say

¹⁵Dr. W. D. Thomas, "The Attitude of the Family Doctor to Manipulation", *Ontario Medical Review*, February 1966, p. 121.

¹⁶*Ibid.*

¹⁷*Ibid.*

¹⁸W. I. Wardwell, *op. cit.* Interestingly, and significantly from the standpoint of interprofessional tensions, the osteopaths refer to orthodox medicine derisively, as the "allopathic" or "countersymptomatic" profession.

so) spine-chilling. The "spectacular cures" are, on the other hand, seldom mentioned. This is a pity, for the doctors have a reasoned case. Roughly, it is that manipulation needs a very high degree of skill, both in diagnosing whether it should be used at all and in practising it. At present the chiropractor's training is not sufficient — on either of these counts — for the "difficult" cases; but neither is the general practitioner's, or (come to that) most doctors', in spite of their infinitely greater medical knowledge.¹⁹ For this reason, it is difficult to see that the recommendation of the College and the OMA that chiropractors should practise only on referral by a physician (any physician, presumably) provides a satisfactory answer to the problem. It is clear that many doctors are not prepared to refuse to refer (proposals to make this practice unethical have been several times defeated in the medical associations). Thus medicine does not like chiropractic, but it is not prepared to go the whole way and put it out of business.

It is unfortunate, from the doctors' standpoint, that the attitude of the profession should be so ambiguous; for it provides their opponents with just that measure of basis in fact, as Wardwell puts it, to support a charge of hostile discrimination. Nowhere is this more apparent than in their stand on chiropractic theory.

Chiropractic theory is dismissed as false; yet doctors constantly call for proof. It is worth noting, in this connection, that the College does not feel that Christian Scientists or faith healers are in any way comparable to chiropractors, on the rather curious ground that a person (an adult) has the right to refuse medical assistance if he wishes. But if resort to a chiropractor without referral is not "refusing medical assistance", what *is* it?²⁰ The Hall Commission — not surprisingly — found the question of the "scientificness" of chiropractic "beyond its competence to solve". Yet it thought that the Lacroix investigation (then being conducted in Quebec by Mr. Justice Lacroix) would be "definitive" and "have application not only to the situation in Quebec but throughout the rest of Canada". This may tell us a lot about the faith we have in Royal Commissions but fails to explain how a lawyer could be expected to resolve a scientific question. It should have occasioned no surprise when the Lacroix Report answered practically every question about chiropractic except the most important one (or, at least, the one

¹⁹Dr. W. J. Melvin told the Committee on the Healing Arts (hearings in June 1967) that an untrained person, *including a physician untrained in manipulation*, cannot manipulate as well as a chiropractor or other person trained in the technique.

²⁰In fairness to the College it must be pointed out that they believe that the "cults" would become illegal if the practice of medicine were defined in the Medical Act (we have already commented on this proposal, above). They would clearly like them to be so, though they would make exception in the case of "ordained or otherwise accredited members of established (sic) religious bodies" (but this raises precisely the difficulties we referred to in Chapter 11, difficulties of a moral as well as a practical nature).

that doctors apparently regard as most important — namely, is chiropractic scientifically valid? (In fact, they “know” it is not, but they demand public proof.)²¹

The Ontario College has now called for a similar inquiry in Ontario, this time by “a totally independent . . . Commission of scientists of unimpeachable qualifications and integrity”. Without wishing to give offence, this is rather like asking the Vatican to set up a commission of totally independent and unimpeachable scientists to decide whether the bones are “really” those of Saint Peter. In these matters, what counts is faith, not evidence: those who oppose chiropractic do not need convincing, and no amount of “scientific” evidence will dissuade those who believe already. And, as the Executive Secretary of the Canadian Chiropractic Association remarked in a letter to the *Toronto Globe and Mail*: “If medicine insists on using individual errors as the yardstick for determining the value of a profession, then they will have to stand before that same yardstick themselves.” Objectively this may be irrelevant, but it is likely to strike a responsive chord in the breasts of many members of the public, particularly those with pains in the lower back.

Naturopaths

Many of the comments on the doctors’ attitude to chiropractic may be held to apply equally to naturopathy. It is surely going much too far to refer to the naturopaths’ concept of treatment “by the use of nature’s agencies, therapeutics, processes and products” as “meaningless jargon”.²² It is true that the modern G.P. is more likely to pump us full of antibiotics than to prescribe sunshine and exercise; but have they so soon forgotten the Mediterranean cruise and the advice to “take the cure” that their forefathers prescribed, often with good results? In fact, it is hard for the layman to accept the doctors’ contention that naturopathy is “scientifically meaningless”. If a doctrine attempts to stress the benefits of nutrition and vitamins but fails to use the right medical jargon, does this make it unscientific? It may very well be that it is, but the doctors will have to make a stronger case than mere abuse.

²¹The College says in its brief to the Committee on the Healing Arts: “A substantial volume of fact and scientific opinion has accumulated which supports the contention of the College that the theory of chiropractic is founded on false premises.” If this is so, why ask for an inquiry, except as a propaganda measure? The Ontario medical profession must make up its mind whether it wishes to outlaw chiropractic or see better-trained chiropractors co-operating with doctors. Mr. Justice Lacroix’ suggestion that the chiropractor should serve a hospital internship of at least one year, for instance, is brusquely rejected by the College. The suggestion was prompted by the belief that this might help the chiropractor to better recognize cases in which manipulative treatment can be properly administered by a chiropractor. The College says: “It is inconceivable to this College that any period of internship could make up for the lack of a scientific premedical and medical education” — a singularly unhelpful reply. The nub of the Lacroix Report was that manipulative techniques have proved to be a valuable method of therapy but that their application must be conditioned by “differential diagnosis”.

²²Brief to the Committee on the Healing Arts, College of Physicians and Surgeons of Ontario.

Again, the College's contention that:

. . . they (i.e., naturopaths) deny totally or in large measure the preventive values of smallpox and Salk vaccines and do not accept the scientific conclusions respecting infectious diseases generally. Surely any group of practitioners adhering to such a medieval philosophy is completely unworthy of legislative recognition . . .²³

is ill-advised, to say the least, given the profession's own record in these matters. This is not to deny the existence of quackery and fraud: these are matters of public record. But, in our opinion, the evidence presented by the medical profession in Ontario is not sufficient to warrant their recommendation that the practice of naturopathy should be banned in the province.²³ The answer, rather, may be to bring it under a firmer measure of public control.

Podiatrists

In the eyes of the medical profession, the podiatrist occupies a position intermediate between the "in-group" of paramedical people, and the "out-group" of independents, to use no stronger term. The College considers that podiatrists perform a useful function; moreover, since many of them work in or for hospital clinics or under the direction and prescription of a medical practitioner, they are part of the paramedical services. Large numbers, however, are in private practice. The chief cause of concern to doctors is the desire on the part of podiatrists to perform "surgery of the foot", to administer anaesthetics for this purpose, and to prescribe drugs for internal use. They are also, and in this case, in our view, not unreasonably, concerned about the ambitions of the organized "discipline" to become "specialists in foot care". In this instance, a discipline is claiming²⁴ not merely to apply certain specific techniques or a certain philosophy of medicine to the practice of healing, but to have virtually sole rights to the treatment of a specific part of the human body; in effect, as the College puts it, "to practise as junior counterparts of orthopaedic surgeons". If this is really the claim, it is surely preposterous, and the lay public would recognize it as such.

In this connection, it is worth noting some facts that emerged from the College's inquiry into the use of podiatrists in certain hospitals in the province. In one hospital, podiatrists are addressed by the title "Doctor" by most of the patients and "by certain of the Nursing Staff". In another hospital:

The podiatrist injects local anaesthetic for minor procedures on the feet when it is deemed necessary (by the podiatrist). If they were not permitted to do so, many of the patients treated . . . would go without treatment. *It is unreasonable to expect a medical doctor to attend the podiatry clinic for the simple purpose of injecting a few cc.'s of local anaesthetic into a toe, as we do not have sufficient practitioners of medicine to provide this service I believe that our podiatrists are more skilful*

²³*Ibid.*

²⁴Or, at any rate, appears to be claiming.

*in the use of local anaesthetic in the foot than most of our junior internes. Their judgment . . . is also better than that of a junior interne There is no doubt that these men render a valuable service, and treat certain conditions of the feet with greater skill than that possessed by most medical doctors. They have taken a special interest in this field which is largely ignored by the doctors and to some extent demeaned by the attitude of the medical practitioner. A competent podiatrist should be able to recognize conditions which are beyond his practice, and up to this point we have trusted them to do so. I personally know of no instance in which the podiatrists have attempted to treat conditions beyond their competence.*²⁵

In this hospital "the podiatrists treat corns, callouses, in-grown toe-nails, warts, etc."; but in another "they are not permitted to do such procedures as in-grown toe-nails" and they are "not permitted to use or inject local anaesthetics". The staff has been told not to call them "Doctor", and on one occasion one of the podiatrists complained and said he would refuse to work there unless they did.

Optometrists

Apart from the usual troubles about the use of the designation "Doctor", the complaints of the profession about optometrists relates primarily to the scope of their practice. The Ontario Optometry Act permits optometrists to prescribe and dispense "ophthalmic appliances". This permits them to fit contact lenses and to prescribe "ocular callisthenics for the relief or correction of any visual or muscular error or defect of the eye"; thus they have been able to "openly enter" (as the OMA puts it) the field of diagnosis and treatment of, for example, children suffering from reading difficulties: in brief, to treat conditions that may be early signs of serious eye or (since the optic nerve is part of the brain) brain disease. The College's view is that, although the need for the services of the optometrist is clearly recognized, he should not be permitted to use drugs for refraction, to treat perceptual difficulties, or to prescribe ophthalmic appliances other than spectacles. Within the limits of the present training of optometrists, this is a reasonable demand; but it does not touch the issue of the improvement of that training — its feasibility, and its economic and social desirability. It is not our business, however, to discuss this matter in this report.

Pharmacists

We have touched briefly on the pharmacist in earlier chapters. One issue, as we saw, is competition between the doctor and the pharmacist in the matter of dispensing. On the whole, the official position of the Ontario profession has been to take a "soft" line with the organized pharmacists, partly, no doubt, because it does genuinely raise for the profession a matter of traditional ethics—a long-standing attitude of opposition to doctors "entering into trade" and making a profit from the sale of goods and appliances. To what extent involvement with the drug

²⁵Emphasis added.

manufacturers is a factor in dictating the "softness" of the line is not known, but this has likely been influential.

The predominating issue, however, concerns the future role of the pharmacist vis-à-vis the medical practitioner, an issue that has been precipitated largely by the modern drug trade. John Turnbull of the Canadian Pharmaceutical Association told the 1967 CMA Conference that:

It is a very common misconception that because it is no longer necessary for the pharmacist to personally prepare and simplify the majority of his medicaments from crude drugs and to compound them into special pharmaceutical form, his work has been simplified. On the contrary, the increasing complexity of modern medication and the resultant opportunity, and in fact, the need for pharmacists to become clearing houses of information on medicines continues to demand more and more knowledge to the point where . . . his role is becoming dependent not so much on what he does as on what he knows — a consultant in matters pertaining to drugs.

It is impossible — and it would be inappropriate — to discuss here all the implications of this statement. Its ramifications go well beyond a discussion of the role of the pharmacist narrowly defined: for it raises the whole issue, economic, social and moral, of the private and highly competitive drug trade.²⁶

Dentists

Last we will consider the dentists (in Britain, dental surgeons), an old, now highly respectable and well-established profession, which is hardly on a par with most of the others we have been discussing. On the whole, as we observed earlier, their

²⁶It may be worth noting, for purposes of comparison with recent findings of both official and unofficial bodies in Canada, the following from the recent Sainsbury Report on the pharmaceutical industry and the British National Health Service:

- (i) some 35% of proprietary pharmaceutical preparations prescribed by NHS doctors are undesirable (obsolete, ineffective, or irrationally combined).
- (ii) the pharmaceutical industry puts almost as much energy (and money) into promotion as it does into research.
- (iii) nearly half the industry's promotion budget is spent on representatives ("detail men", in Canada) who visit doctors not, says the industry, to sell, but to inform them about new developments. But:
 - (a) a survey of advertising in a medical journal showed that in 22 out of 45 advertisements unwarranted claims were made and serious side effects were not mentioned or glossed over.
 - (b) one in three doctors selected representatives as a source of information, but only one in eight thought they were the best source about the efficiency of the medicines they were "representing". In general, the attitudes and practices of doctors in regard to advertising were such that the Committee concluded that the industry's promotional activities were a socially wasteful way of educating the doctor.
 - (c) in three cases brought to the attention of the Committee, representatives were briefed by rehearsing a prepared script, which made them sound like salesmen not even trusted by their employers.

(SOURCE: Report on the Report in *New Society*, October 5, 1967.)

relations with the medical profession in Ontario have been characterized by a cool watchfulness. Certain issues, including hospital privileges and the role of the dentists in the hospital, are a matter of continuing concern. Of particular interest is the issue of the proper role of the oral dental surgeon in relation to that of certain surgical specialists.

Early in 1966 the Board of Directors of the OMA sought the advice of the Association's Section on Plastic Surgery on this matter. The principles then suggested were presented to the Committee on the Healing Arts in the OMA's brief. The first principle stated that the dental surgeon plays an essential role in providing health care to the people of Ontario and "requires the opportunity to collaborate with the physicians and surgeons in the care of patients both inside and outside the hospital". This somewhat patronizing pronouncement (it may not have been intentional) was followed by a number of other observations which stung the Ontario Dental Association to reply through the editorial columns of its journal. The OMA, it said, "has suffered some damage to its plumage by the Press releases (sic) occasioned by other sections of its Brief and it has added not a cubit to its stature by its archaic declamation against dentistry."²⁷ The ODA's rebuttal is illuminating, not only in respect to medical-dental relations, but in respect also to the wider issue of the way the medical profession sees its place in the total health service complex.

Medicine has the legal right to treat any part of the body, and for obvious reasons. In emergencies or in order to save life many things are permissible that would not normally be accepted. This principle, we think, should be recognized by Medicine in its relationships with Dentistry. Because (the medical profession) has the legal right to practise dentistry in emergencies or when a dentist is not available, it should not give them the moral right to practise elective surgery in an area in which they may lack knowledge and training and when oral surgeons (i.e., dentists) are available. The public and the politicians would be shocked if they knew how little the average physician knows about dentistry. This is not said in any sense of criticism or derogation. It would be irrational to expect otherwise The average physician knows little more about Dentistry than any intelligent layman and it should not be expected that he should.²⁸

Oral surgery, the editorial argues, is a specialty of dentistry, not medicine. "We know of no undergraduate training in Medicine that offers instruction in Oral Surgery. It has been developed under the aegis of Dentistry."

Dentistry is in itself a specialty and dental students did, and I am sure still do, spend more time on the anatomy of the head and neck than the medical students.²⁹

²⁷*Ontario Dental Association Journal*, August 1967.

²⁸*Ibid.*

²⁹*Ibid.*

Moreover:

It is a misstatement to say that oral surgeons are not trained to cope with what may occur, such as "haemorrhage, cardiac arrest and other serious episodes". The cult for slashing open the patient's chest and manually massaging the heart has gone out of style. It got some people's names into the paper but the patient invariably died. Closed heart massage, intubation and oxygen insufflation can be as capably performed by oral surgeons as by anyone else and they are trained to do so.³⁰

The editorial concludes, caustically:

We heartily agree with the resolution that "there must be cooperation between the medical and dental professions". We believe that we have always sought it, and will continue to do so The Brief of the OMA seems *prima facie* evidence that our efforts have not always been reciprocated.³¹

Conclusion

In an editorial, "Healing the Divisions in the Healing Professions", dated July 8, 1967, the *Globe and Mail* commented unfavourably on the "interprofessional jealousy almost uniformly displayed by every group involved in the healing arts for every other group They persist in being competitors when they ought to be partners". In our view, this judgement is too harsh. From one point of view the field of the healing arts look "balkanized" — to use the editorial's term for it. But on the other side, one must take account of a very real area of consultation and cooperation that exists between the various professions. Where their mutual interests are concerned, there is little difficulty: the trouble arises when the groups feel their status and aspirations are thwarted by the activities of others. It is precisely at this point that the concept of professional self-determination must give way to the public interest, and it is for precisely this reason that state registration must always be subject to close public scrutiny and control.

³⁰*Ibid.*

³¹*Ibid.*

Chapter 16 The Medical Profession and the Government¹

Who shall decide when doctors disagree?
—Alexander Pope, *Moral Essays*, Epistle III, i

Social scientists have commented on the fundamental antipathy between the healing arts and “bureaucracy” (i.e., government and public administration).² This antipathy is not very surprising, for the medical profession (in most countries of the West at least) is not only a pressure group but a self-governing corporation — in fact, or in intent, though not necessarily in legal form. The feeling of many doctors, in many parts of the world, was no doubt accurately expressed by one “indignant” Saskatchewan doctor who wrote (to the Chairman of the Medical Care Insurance Commission at the height of the medicare crisis in the province in 1962):

The doctor is a reasonable, highly-trained, competent person and should be answerable to nobody, individual or corporate or government, only to the patient and to the College of Physicians and Surgeons.³

This is an utterly untenable — indeed, illogical — position, but it is understandable. There exists a long tradition in the “learned” professions of resistance to interference with their autonomy, particularly from the State, and it would have been surprising if the Canadian medical profession had proved an exception.

In this concluding chapter we examine the Ontario medical profession as a pressure (or political interest) group: its nature as a self-governing corporation has been extensively documented in earlier chapters.

General Pressure Group Activities

In a study of the political activities of the British Medical Association,⁴ Professor Harry Eckstein distinguishes: the *form* that pressure group politics takes,

¹This chapter may be read in conjunction with Chapter 7, on the structure and influence of the medical profession in Ontario. The evidence on which some of the conclusions of this chapter have been based cannot be made public without breach of confidence.

²For example, Malcolm G. Taylor, “The Role of the Medical Profession in the Formulation and Execution of Public Policy”, *Canadian Journal of Economics and Political Science*, Vol. 26, 1960, p. 108; and Oswald Hall, “Half Medical Man, Half Administrator: An Occupational Dilemma”, *Canadian Public Administration*, Vol. 2, 1959, p. 185.

³Quoted by Robin Badgley and Dr. Sam Wolfe, *Doctor's Strike*, Macmillan of Canada, Toronto, 1967, p. 86. For an account of the “Saskatchewan affair” see Appendix VII at the end of this report.

⁴Harry Eckstein, *Pressure Group Politics*, Stanford University Press, Stanford, 1960.

the factors that determine the principal channels and means through which pressure groups act on government, and the character of the relations between them and the various organs of government; the determinants of the *intensity and scope* of pressure group politics; and the *effectiveness* of pressure groups. In discussing the *form* of pressure group activities, he suggests, we must look at the channels of action on which the groups concentrate. The determinants of the selection of channels are, he argues, 1) the structure of the decision-making processes which pressure groups seek to influence; 2) the activities of government; and 3) prevailing social attitudes about the legitimacy of pressure group activity.

From a study of available documents, and from interviews with doctor-politicians (i.e., leaders of the medical profession), members of the legislative assembly in Queen's Park and other people prominent in the health field, we conclude that medical pressure group politics in Ontario is still relatively undeveloped. Ontario has a parliamentary system of government in which the executive — ministers, backed by a burgeoning bureaucracy — has been steadily growing in cohesion and influence. It is not, therefore, very surprising that such political activities as the Ontario medical profession engages in at the provincial level tend to be concentrated on the executive rather than on the legislature. There is only one doctor M.L.A. (the Minister of Health himself),⁵ and the OMA seems relatively uninterested in parliamentary lobbying. Even at the executive level, however, relations with ministers and civil servants have been rather sporadic and ad hoc. More attention has been paid to public campaigning (the least direct form of pressure group activity, aimed at influencing politicians and civil servants via the voter and public opinion), but even this has been handled rather maladroitly and in an amateurish fashion.

The reasons are probably more complex than might appear at first sight. It is sometimes argued that pressure group politics is relatively undeveloped in Canada. We do not find this plausible. The same was argued of Britain — until 1950, when political scientists began to study the situation. Then it was "found" not only that it was the staple of British political life, but that it was probably more highly developed there and more closely meshed into the system of government than was the case in the United States, long considered the *fons et origo* of The Lobby.

Doctors, we are told, are by nature apolitical. They mostly come from middle-class, professional backgrounds. Professor William A. Glaser reports, of American doctors:

Few occupations rank lower on political or economic interests as measured by the Allport-Vernon-Lindzey Values Scale. Other personality tests show

⁵There were seven doctors in the last federal Parliament, and four doctor-Senators. At the provincial level, there were, in 1967, one in the Alberta legislature (the Minister of Health), one in British Columbia, one in Manitoba (the Minister of Education), nine in Quebec (two of them ministers), three in Newfoundland, three in New Brunswick (one of them the Minister of Health), six in Nova Scotia, and three in Prince Edward Island.

that doctors focus their life interests around their work and its scientific and technical content to a degree equalled by few other occupations. Medical education and medical practice produce very specialized technical knowledge and manual skills which are very different from the knowledge and skills appropriate to bureaucratic, legislative, or political jobs. Even administrative work within medical institutions is unpopular among doctors and is avoided by most.⁶

Doctors are highly paid and have few opportunities to abandon their work for temporary or permanent political activity. Occupational commitment is strong;⁷ the group is strongly inward-looking.⁸ They have a long tradition (mythology?) of charitable work, of freedom from government interference, and of individualistic rugged enterprise. One commentator, even, has called them "the last bastion of the Protestant Ethic". There are few doctors in the Canadian federal and provincial legislatures. The same is true of the United States (there were only four in the 86th Congress, for example);⁹ and in Britain only twelve were elected to the 1966 Parliament. Says Professor Glaser:

Political activity by a doctor sometimes is disapproved by his colleagues on the grounds he is advertising his practice and thereby violating professional ethics. Within the profession itself, a doctor's reputation and success depend on his medical achievements, and his community services carry little weight.¹⁰

It is, indeed, suggested, in an unpublished paper kindly shown to the author by a colleague, that the typical "medical politician" is an untypical doctor — often an unsuccessful one. Our own observations in Ontario and at the federal level lead us to conclude that the latter part of the statement is harsh and, in many instances, untrue: though clearly it is almost impossible for a man to devote his life to medical politics *and* rise to eminence in his profession.¹¹

⁶William A. Glaser, "Doctors and Politics", *American Journal of Sociology*, Vol. 66, November 1960.

⁷Surveys conducted by the Association of American Medical Colleges and the Bureau of Applied Social Research showed 61 per cent of a sample of medical students reporting that medicine was the only satisfying career, but 68 per cent of law students saying that law was only one of several equally acceptable occupations. *Ibid.*

⁸In one unpublished study of a large general hospital, 75 per cent of the doctors' conversations were with other doctors (A. F. Wessen, "The Social Structure of a Modern Hospital", Ph.D. dissertation, Yale University, 1951).

⁹But five doctors signed the Declaration of Independence: those were the days when "the practice of physic" could be combined with other occupations.

¹⁰William A. Glaser, *op. cit.*

¹¹On the other hand, men of eminence — as doctors — may exercise great political influence in the profession: but they are not medical politicians in the sense intended by my informant. "Medical statesmen" would perhaps be a better term for them. It is often alleged that it was the "medical statesmen" (of the Royal Colleges) who "sold the profession (i.e., the British Medical Association) down the river" in 1948, when the fate of the British National Health Service was in the balance.

Moreover:

. . . an important barrier restricting doctors' political activity may be a latent impatience and hostility towards politics . . . Medical journals sometimes publish patronizing harangues against politicians.¹² In two surveys, doctors and medical students described politicians as people less intelligent, moral, and dignified than themselves.¹³

Glaser quotes the editor of a leading medical journal:

The doctor's dilemma today emerges from the fact that politics is a dirty-hands business, and medicine has always been a clean-hands profession. Healing and heeling don't go together.

(It should be remembered, however, that the view of politics as a dirty business is widespread in America and is by no means confined to business and professional groups.)

The attitude of doctors to their government confreres is illuminating. In a National Opinion Research Center study of medical students published in 1956, only 4 per cent said they would be "very interested" in working for the Veterans Administration and only 5 per cent said they would be similarly interested in working for the U.S. Public Health Service. Their reasons for disliking government medical jobs included, prominently, "regimentation", "the hierarchical organization of government agencies", and (inevitably) "unsatisfactory doctor-patient relations".

Badgley and Wolfe comment that:

The so-called conventional wisdom of many medical teachers and the organized medical profession has tended to produce generations of doctors who have learned (sic) to stereotype and over-simplify major aspects of the real world, leading to judgments about society in general and economic matters in particular that are not based on dispassionate assessment of factual evidence

As one medical spokesman has noted We're bemused by slogans and pat phrases that no longer have much to do with reality The organized medical profession has adapted poorly to the realities of the medical industrial revolution.¹⁴

Nevertheless, these attitudes — if they are shared by Canadian doctors (as in general seems likely¹⁵) — produce very different results in the two countries. They do not prevent the American Medical Association and its State Medical Societies from being among the most aggressive (and at times most unscrupulous) of all the organized political interests in America, utilizing to the full all the modern techniques of pressure, influence and manipulation, sometimes almost to

¹²Author's note: Some can be seen from time to time in the *Ontario Medical Review*.

¹³William A. Glaser, *op. cit.* The surveys referred to appear in Professor Glaser's footnotes.

¹⁴Robin Badgley and Dr. Sam Wolfe, *op. cit.*, p. 156.

¹⁵Our interviews with Ontario doctors tend to confirm this.

the point of unconstitutional behaviour; behaviour that contrasts equally with the generally quietist, hands-off stance of the organized Canadian medical profession and with the well-integrated, suave, "velvety-smooth" and "statesmanlike" approach of the BMA.¹⁶

The differences are to be sought, not so much (or not simply) in differences of basic attitudes — on the contrary, there appear to be remarkable *general* similarities among the three countries¹⁷ — as in (as Eckstein puts it) "the *interplay* of governmental structure, activities, and attitudes" and "the kinds of relations which predominate among the groups and governmental bodies (concerned)". Except for rather special purposes (the expressing of views ad hoc on medical and related technical health legislation), which could be handled easily enough by occasional deputations to Queen's Park, there has been little occasion, until quite recently, for the Ontario Medical Association to get continuously embroiled in politics. The growth of provincial government functions and of provincial government bureaucracy is, again, a relatively recent phenomenon. And doctors often still question the legitimacy of political action. Among the rank and file there is a tradition of individualism and the "frontier-spirit" and the feeling that (as Eckstein puts it) "actors should act on each other through the spontaneously adjusting mechanics of the market rather than through the political process". Throughout the nineteenth century, the British Medical Association "tried, almost desperately, to remain purely a professional association, to the point of provoking outright mutiny by the more politically-minded doctors".¹⁸ The attitude of the OMA leadership today indicates a similarly painful struggle to come to terms with the realities of a changing situation. It is not so much that the leadership looks upon dealing with government as illegitimate, as that it fears the consequences for its autonomy of doing so. Hence, for example, its often-reiterated position that it will never negotiate with government about its Fee Schedule. The basic reasoning behind this seems to be that once it does so, the game is up. As one doctor-politician put it:

In Ontario, the Medical Association has refrained from coming to any agreement by inference or by negotiation concerning payments for medical care by a government agency. Members of the OMA have been advised

¹⁶See, for example, the address of the General Secretary of the BMA, Dr. Derek Stevenson, to the Centenary Conference of the CMA, June 1967, for an excellent taste of the "polite-front tactics" of a major British pressure group. (The speech is published in mimeo. by the CMA.) The unpretentious Toronto house used as a headquarters by the CMA (it is moving into grander quarters in Ottawa in due course), with its cheerful informality and paper coffee cups, compares markedly (and in the author's view by no means unfavourably) with the splendour of BMA House in Tavistock Square, renovated by Sir Edwin Lutyens, with its quiet courtyards and lawns, fountains, and upper middle-class secretaries.

¹⁷Though there are significant cultural differences between the countries, medicine (like physics, for instance) is a singularly "international" profession in its basic outlook: it has a common "language" and shares techniques which cross national frontiers. This is perhaps true also of the other major professions, though to a lesser extent.

¹⁸Harry Eckstein, "The Politics of the British Medical Association", *Political Quarterly*, Vol. 26, p. 345.

to deal only with their patients. It is a clearcut decision (though as we have seen, and as the OMA admits, a great number of Ontario doctors ignore it). Whether it is workable remains to be seen. The doctors of Ontario have the strongest provincial medical association in Canada. Their leaders have influenced Canadian medico-political thought profoundly for generations. Today they are standing alone. Perhaps they are right. Their colleagues in other parts of Canada are anxiously watching their course.¹⁹

On the other side of the coin, however, serious doubts arise about the adequacy of the existing political and administrative machinery for handling the Ontario doctors' legitimate fears and claims. As Eckstein says (correctly): "to press upon a government is itself, in a way, a form of commitment to it". This is precisely what the OMA fears; and it must be said frankly that the evidence suggests that the Government of Ontario has not always been as open and cooperative with the doctors as it might, and indeed should, have been. The executive itself is undergoing a period of painful readjustment to meet new challenges and responsibilities, of which the future of medical care in the province is one of the most important; and this has to be recognized. But if doctors are to cooperate with governments, governments must be prepared to cooperate with doctors. Our impression is that there is a curious reluctance on both sides to have anything more than the essential minimum of dealings with the other, and then only when forced to do so. There seems little doubt that, in the Saskatchewan crisis of 1962 (leaving aside the party political and deeply divisive social forces),²⁰ the provincial government was singularly inept in its handling of the doctors' fears and legitimate expectations; and that the ultimate confrontation could have been avoided if there had been a better atmosphere of trust and understanding created by close consultation at an earlier stage:

The government clearly had wide breadth of experience . . . it had the administrators. It had the economists. But it left its flanks wide open to attack. Not only did it fail to create trust among the doctors and to neutralize the anxieties of a proud profession, but it also lacked administrative foresight on key issues . . .

When the government introduced its medical care legislation, its leaders seriously misjudged the rigid position taken by the doctors . . .²¹

A continued failure to bring about closer and more intimate working relationships between the Government of Ontario (in particular the Department of Health) and the doctors of Ontario could have very serious consequences: for the people, for their political system, for the provincial medical profession itself — and indeed, because of the national importance of the OMA, for the Canadian medical profession as a whole. There is no chance that the OMA and its members will commit themselves to a system that they progressively mistrust; on the con-

¹⁹Dr. Frank Turnbull, Vancouver, B.C., addressing the CMA Centenary Conference on "Negotiations of Medical Profession with Government". Words in parentheses added.

²⁰For details, see Appendix VII at the end of this report.

²¹Robin Badgley and Dr. Sam Wolfe, *op. cit.*, pp. 168-169.

trary, they will become increasingly disaffected and intransigent. Universally, in a pluralistic political system such as that of Canada, the exclusion of important groups from access to the centres of power and decision-making leads to intrigue and (if uncorrected) to irrational and even violent action.

Pressure Group Politics in Ontario

So far this chapter has dealt in generalities, though significant ones. It is now time to turn to a more detailed consideration of the medico-political process in the province.

The OMA is not inexperienced in the business of dealing with politicians.²² One occasion we may note is the controversy that arose in 1922-1923 concerning a proposed definition of the practice of medicine in the Medical Act.²³ This was not the first occasion on which the Ontario medical profession had mounted an attack on "irregular practitioners", nor was it to be the last. The decision to seek a legal definition was made by the Joint Advisory Committee of the OMA and the College. Other groups were brought into the campaign when representatives from the universities and groups affiliated with the OMA joined a delegation to the provincial premier (Mr. Drury). The premier's response was to establish a "Committee of Three" to confer with him: one member to represent the OMA, one the College, and one the universities. This Committee persuaded the premier to agree to amend the Act, and its members conferred with the Attorney-General's department during the actual drafting stage of the bill. At this point, a campaign to persuade the legislature was launched, apparently on the advice of the premier. M.L.A.'s — and particularly members of the United Farmers (the majority) party — were approached individually, and letters were sent to the family doctors of all the members of the party, exhorting them to persuade their legislator-patients to support the bill. The OMA General Secretary (Dr. Routley) personally approached many doctors: the result was a "flood" of telegrams to the premier's office ("the biggest he had ever seen"). On several occasions the premier advised the doctors on how to proceed and identified for them the weak links in the support for the bill. The premier was himself opposed to the originally proposed definition; but after it was reconsidered by the doctors, a formula was found that satisfied him. It did not satisfy the party or the house, however (an election was pending), and it was some time before a minister (eventually the Minister of Labour) could be found to recast the bill. Opposition was eventually worn down, and on May 1, 1923 the bill was given a second reading.

²²It has also had experience in working closely with government in the administration of public programs, such as the Medical Welfare Plan, which was a product of the Depression and a precursor of later doctor-sponsored medical prepayment plans. It continued in existence until the coming of OMSIP in 1966.

²³A full account is given in Chapter Sixteen of Dr. T. C. Routley's *History of the OMA*, published in the *Ontario Medical Review* for January 1965.

Premier Drury did a first-class job. In the debate which followed it was obvious that every member of the house had at least been exposed to what the medical profession thought and why it thought it. The doctors around the province had done a fine job.²⁴

(The net effect of the bill, which became law in July 1923, was to force drugless practitioners, including osteopaths and chiropractors, to file a formal statement with the Provincial Secretary: it led eventually to the first of the Drugless Practitioners Acts.)

Recently, however, there has been very little parliamentary lobbying.²⁵ Of three prominent M.L.A.'s to whom we talked (one PC, one Liberal and one NDP), chosen by us because of their interest in health matters, none could recall being approached officially by any member of the OMA at any time. One of them was a member of the Conservative caucus committee which studied and revised the OMSIP bill; but he was never approached by the OMA. Nor did the three men know of any other private member who had ever been approached by the Association. The OMA did present its views to the Liberal Party caucus in 1962, but this was because it had been invited to appear: it did not take the initiative.

One of our informants (a PC member) thought the OMA failed to represent either the doctors' or the patients' interests to the government.²⁶ He believed the OMA had few mechanisms and little organization for getting its views across. Whatever moves the doctors make, he said, are viewed with suspicion by M.L.A.'s, since the organization is seen as one with the purely selfish interests of the doctors at heart. Once the doctors try to influence anything, their motives are immediately questioned.²⁷ Moreover, the Association's methods of influencing legislative policy are "haphazard". Every now and then they say something that gets in the press, and they expect the civil service and legislators to read and study their Council resolutions, copies of which they send to all members. They are not a lobby in the strict sense: they do not present well-digested information and logical argument. Sending copies of a pamphlet (such as the one on OMSIP that went to doctors' offices for distribution to patients) is hardly the answer, considering the weight of the average M.L.A.'s mail.

²⁴*Ibid.*

²⁵One former President of the OMA to whom we talked told us that he wished the OMA lobby were "a bit more effective". He referred wistfully to the American system, "where there are no party whips". During his six years as a member of the Board of Directors of the OMA, there had been no concerted policy of approaching individual members of the legislature. There might, however, have been some informal contacts — "all members have doctors and must listen to them and talk to them sometimes".

²⁶The following paragraphs contain an edited version of the notes of one of our research assistants.

²⁷This gentleman cited, as a similar example, the dentists and the fluoridation issue. Many people in politics, he said, argue that fluoridation might have passed at the provincial level were it not for the *support* of the dentists: anti-fluoridationists tended to say if the dentists support it, it must be bad for our teeth.

Our informant was against compulsory medicare: no insurance scheme can do anything about solving the crucial problems of medical manpower and medical research ("the main health problem for his constituents is not paying the bills but finding good quality care"). When the CMA took up the manpower problem in 1962, the press stamped its efforts as simply an attempt to stall medicare; through cases such as this, the OMA has lost faith in the press.²⁸ When he was working in caucus on the OMSIP bill, this member consulted some doctors whose opinions he particularly respected, but they "had no particular connection with the OMA". During the progress of the bill he heard nothing from the College of Optometrists either (though "frequently" from an optometrist who was one of his constituents), and nothing from the dentists; but the chiropractors invited all the members of the caucus to a buffet supper at the Park Plaza.

Another of our informants (a Liberal member) was "struck by what appeared to be the narrow and rigid views of the medical spokesmen" when they appeared before the Liberal caucus in 1962. At that time, however, the OMA appeared to be "dominated by refugees from the British National Health Service". He contrasted the views of the OMA leaders with those of the dentists, chiropractors and "the average general practitioner". He gave as an example the shortage of hospital beds in Metropolitan Toronto. The many complaints about shortage of beds had been "denied" by the Minister and "ignored" by the medical profession. Finally, when patients began to switch to other doctors who had access to hospital beds, the doctors began to complain publicly and the government had to act. This is an example, he argued, of how the OMA takes no action unless the immediate economic interests of the doctors are at stake. On the issue of underpayment of nurses: the doctors, who are in the highest paid profession in the country,²⁹ have done little or nothing to help those who are in perhaps one of the worst paid. Yet if they were genuinely interested in the overall question of providing the best health care, they certainly would do so. He is suspicious of, and somewhat hostile to, the links between the insurance companies and the organized doctors (they "belong to the same social class and go to the same golf clubs", and have "common cause together"). Opposition attitudes, perhaps more than partisan politics as such, emerged in his belief that the OMA "certainly has influence with the present Ontario government". They have too much power, are far too influential. They are second only to the insurance companies in influencing government policy. (It is a familiar Opposition charge that the insurance companies are a major source of Progressive Conservative campaign funds.) This influential medical lobby is unfair to chiropractors and other non-doctor prac-

²⁸A former President of the OMA told us the same thing.

²⁹The average income of doctors in 1965 was \$23,229; the median would be much higher, if only because "doctors" include large numbers of residents and other salary earners.

tioners, and to all doctors from other parts of the world (except "refugees from the National Health Service"?). Most voluntary health groups, he felt, are "weak lobbyists": this may be because so many of them receive grants from the government and are afraid to embarrass it. He gets a lot of mail from optometrists, and "the chiropractors are the best organized".³⁰

A third informant (NDP) thought that, in general, he would expect close tie-up between the present government and the doctors, "because both were Tory", but the "fee-hike" case proved him wrong. Relations between the government and the doctors have not been "energetically cultivated". This is in strong contrast to the chiropractors, who form an "assiduous and active lobby" and have an M.L.A. as their legal advisor. In general, there has not been a careful job of public relations on either side. Before the fee-hike the OMA had very close relations with government,³¹ but recently relations have deteriorated. One of the problems is that whenever the doctors start to complain, their voice is regarded as that of the extremist (sic) fringe of the medical profession. The OMA does not actively cultivate the support of the average member of the legislature: for example, it did not even bother to send them copies of its brief to the Committee on the Healing Arts. In its public relations work (such as it is), it shows "almost a contempt" for the legislature: it appeals to the public, or it does nothing at all. When it does lobby, it tends to go "where the power is".³² He thinks this is bad public relations, though it may be deliberate tactics. The pre-eminent political position of the medical profession is due (he thought) not to the fact that they lobby extensively (since they do not), but to the mystique which the public has built up around them. He thinks they "lean" on this.³³ He is especially interested in mental health, but "the OMA has nothing to say about the mental health issue"; at least, he has not been able to find anything written by the OMA on the subject.³⁴

The OMA expends a limited amount of energy and resources on public campaigns. In the main, it confines itself to press releases, though there is undeniably a general desire on the part of the leadership to foster a "good image" with the public. A scrutiny of the Reports to Council suggests that a very active role cannot

³⁰These comments by prominent M.L.A.'s are quoted, not in the belief that they are necessarily true — or more than half true (though they may be) — but, rather, to present some of the attitudes of provincial legislators towards the medical profession: a very important factor in the medico-political situation.

³¹This does not accord with the OMA's side of the story; moreover, it is incorrect.

³²For example, he suggested that the OMA had probably applied pressure on the insurance companies, "if not through them".

³³The OMA has not pressed harder with its argument that the primary problem in providing medical care is not the inability of people to pay for medical services but the inadequate supply of doctors, because this is a "bogus" argument, he said.

³⁴There is no OMA committee on mental health, although the Association is represented on various mental health agencies.

be assigned to the Public Relations Committee, and there is no separate budget for public relations. Partly, this may be due to a form of members' reactions, many of whom think PR activities are a waste of their money (they may be right).

The channel of communication commonly used by the OMA is a direct appeal to the government and to the civil service. Head office scrutinizes all health bills but not, apparently, the daily records of debates in the legislature (Hansard). Meetings with ministers and deputy ministers tend to be rather formal; of late, however, more emphasis has been placed on opportunities for informal "tea and talk".³⁵ There has probably never been any real difficulty on strictly technical matters: that is, on committees to discuss mainly technical and the more routine administrative matters. The basic problem has been (and remains) to secure a meeting of minds on the larger issues of policy. It is our considered opinion that, whether they like it or not, the medical profession and the government of the province will inevitably be drawn more and more closely together in future in working out a whole range of health care problems. It is totally unrealistic to suppose that they can continue to conduct their business at arm's length, and in an atmosphere of increasing mutual distrust and dislike.

Dr. Malcolm Taylor suggested in 1960 that the informal channels of communication between government and organized medicine in Canada should work well because "there exists . . . a bond of understanding arising from common membership of a professional elite" (i.e., health officials, if not all Ministers of Health, are doctors), and because "in the administrative jargon of the prepayment agencies, 'only a doctor can deal with a doctor' . . .".³⁶ We can see now (partly — but only partly — because of Saskatchewan) that this is far from being the case; indeed, such evidence as we have been able to accumulate points the other way.³⁷

At the federal level, and in some of the provinces, there are encouraging signs of a desire for change. The CMA is anxious to establish better relations with the Department of National Health and Welfare.³⁸ The Association has an "Advisory Committee to the Federal Government", which is clearly an important body in the CMA structure. Recently, the CMA has announced the establishment of a special department of collective negotiations to help provincial associations to

³⁵Interview with a recent President of the OMA.

³⁶Dr. Malcolm Taylor, *op. cit.*

³⁷Sociologists might find the investigation of this problem rewarding. No doubt personal role-conflict is involved; but the tension is not confined to practising doctors *versus* government doctor-administrators. As we have noted, there are tensions, too, between the salaried doctor and the non-salaried, between the academic doctor and the non-academic. That the medical profession is not monolithic in its values and loyalties (as Dr. Taylor apparently supposed) should occasion no surprise. The surprising thing, rather, is that people should ever have imagined that it could be.

³⁸Interview with the General Secretary of the CMA, May 1967.

"become more expert in negotiations with government".³⁹ The OMA is opposed to this, though one former member of the leadership to whom we talked felt that it is a necessary, and indeed an inevitable, step.⁴⁰

In this respect, it is worth noting the views of Dr. Frank Turnbull of Vancouver, who was the chairman of the CMA committee that recommended the establishment of the collective negotiation machinery:

Negotiations between the Medical Profession and Government have rather suddenly become a matter of great importance for Canadian doctors as well as for our governments, federal and provincial. The reason, of course, is Medicare, which cannot operate effectively without working arrangements that are agreeable to both parties. Hitherto there has been a *singular lack of interest on the part of either the medical profession or the government about the need for meetings that might be expected to produce some measure of agreement about mutual problems*. There have been meetings and conferences galore, but they seldom led to satisfactory finite decisions. Our experiences with the negotiation of issues, as a profession, have been limited, irregular, and usually discouraging. Circumstances did not call for an elaborate organization. But a change is occurring at both Federal and Provincial levels. Problems that cannot be resolved by unilateral action have multiplied.

³⁹The Toronto *Globe and Mail* (Monday, June 12, 1967) reported as follows:

The general council of the Canadian Medical Association on Saturday decided that the association should set up a department of collective negotiation, with a full-time secretary "trained and experienced in this area". He, when chosen, is unlikely to be a doctor, officials said.

The council accepted a Nova Scotia-division resolution that each provincial division be prepared to represent all its members — employed and self-employed — in negotiations with employers or paying agencies.

This was agreed over the opposition of the Ontario division.

Dr. Ross Matthews of Peterborough, immediate past-president of the Ontario Medical Association, said this resolution directed the provinces. Ontario was not prepared to accept that doctors are bargaining with one paying body or to set a precedent by agreeing to any bargaining with government. "We are not prepared to put our fee schedule on the bargaining block now, or at any time in the future," Dr. Matthews said.

Dr. F. A. Turnbull of Vancouver told a press conference that the B.C. division of the CMA undertook collective negotiation with the British Columbia Government on behalf of doctors when the B.C. medical plan was brought in. The B.C. Medical Association's action on behalf of its members met with no complaints, he said.

The key point is that such negotiations do not commit a doctor to anything: The individual doctor always retains the right to opt out of a plan. A medical association is not entering a contract on behalf of its members, but negotiating an arrangement it has reason to believe will meet with the approval of the majority, Dr. Turnbull said.

⁴⁰He also asserted that the fact that "most Ontario doctors choose to deal directly with OMSIP may show that they do not agree with the official position of the OMA". Another senior OMA office-holder to whom we talked, while reiterating the official OMA position, indicated by his attitude that he, too, thought that this would have to come.

. . . Medical Associations that undertake to negotiate with Government for the economic welfare of doctors-in-practice are moving into an area without any landmarks and indeed without any maps One of the hardest lessons for doctors to learn is that government's first weapon is delay. This tactic is practised with consummate skill. Unless we are able to find representatives who are aware of the technique and impervious to exhaustion we fare badly

The attitude of Medical Associations across Canada to the situation that has been created by Medicare varies from Province to Province. This is partly a reflection of Canada's unique political structure. Health care is a provincial responsibility and arrangements in each Province have been influenced by variations in geography, economy, and political atmosphere. The pressure for universal, tax-supported Medicare was initiated by the left-wing political parties. It was natural that Saskatchewan should be first to introduce a full-scale plan. Our colleagues in Saskatchewan were in a position reminiscent of the Canadian troops at Ypres who withstood the first gas attack in World War I. There was no precedent. Under the circumstances, which have been sadly distorted in some published accounts, they had no alternative but to stand and fight. They made some mistakes, but they did gain their principal objective, the right to opt out. Above all, the Saskatchewan crisis served to alert Medical Associations all across Canada to the importance of a strong, well-ordered, efficient organization to represent the doctors-in-practice.

The doctors of Quebec have displayed a striking ability to recognize the realities of the new political situation. Within two years they have become completely reorganized. They have formed "syndicates" for the sole purpose of collective negotiation, under the provisions of a Quebec law concerning the organization of professional people, which was enacted over twenty years ago. A comparable law does not exist in any other province. We are eagerly waiting for news of the Quebec experiment.⁴¹

In an article on the fifth anniversary of the Saskatchewan doctors' strike, the *Medical Post* commented editorially:

What does become apparent from the vantage point of five years is that the strike could have been avoided *if there had been better communication between the government and the College of Physicians and Surgeons; if the government had been more adroit in handling the pre-planning of the medicare plan; if the college had observed a more democratic attitude among its own members (you were either for or against and if you were against you were a heretic); if the college had not let itself become the dupe of politicians who saw in the doctors' fight the ideal formula for overthrowing the government.*

We do not believe that a strike is "the only weapon which has meaning both for the government and the population at large," as the OMA has stated. Certainly, not for physicians. Arbitration, access to the courts and

⁴¹Address to the CMA Centenary Conference, 1967; CMA, mimeo. as "Negotiations of the Medical Profession With Government". Emphasis added.

working within the framework of party politics are all proper avenues of redress. An examination of the Saskatchewan debacle shows the strike tactic only results in the profession losing more (in self-respect and harmony) than it can ever gain.⁴²

We are convinced that the responsible leadership of the OMA and the majority of Ontario doctors are aware of this, in spite of their occasional angry pronouncements to the contrary. But much more is required of both sides than the avoidance of a violent confrontation. As Dr. Derek Stevenson, the General Secretary of the British Medical Association, put it in his Centenary address to the CMA in Montreal:

With the introduction of state sponsored health services, medicine and politics have become inextricably mixed and the development of a parliamentary lobby and a vigorous press campaign have become inescapable sequelae Doctors are in constant disputation with Government on matters which go far beyond terms and conditions of service. Basically they are concerned with the problem of providing conditions under which doctors can practice their art with complete clinical freedom exercising their skill with the minimum of interference by the State . . . there must be an understanding of the basic difficulties involved and each side must respect the integrity of the other. The Government must respect the wish of doctors to be assured of a free hand in the treatment of their patients under conditions which relieve them of financial anxiety and allow them time for reasonable relaxation, postgraduate study and research. Doctors for their part must respect the will of the community expressed in a free democracy by Parliament and be flexible in adapting their own views for the greatest good of their patients. Negotiation — if it is to mean anything at all — can never be a matter of black and white. Whilst neither side should ever be asked to yield a matter of principle, discussion and argument can usually lead to decisions which, whilst benefitting the patient, enable both sides to meet halfway.

. . . So far I have dealt only with the methods through which negotiations can be conducted by the time honoured method of collective bargaining. It is one thing to have the means, another to make them work, and here the prime responsibility rests upon the Minister concerned and the leaders of the profession. Much will depend upon their respective personalities and the respect and confidence which they enjoy of their colleagues. A strong Minister whose views carry weight with his Cabinet colleagues can be of great help. Ministers after all are only human and are amenable to persuasion and argument. If the profession's case is sound, a Minister will normally respond, but this is of little use unless he can carry his colleagues and Parliament with him. Equally, the leaders of the profession must be prepared to listen to counter argument and from time to time accept responsibility for agreements which fall short of what they were instructed to obtain. This can cause difficulty in a highly democratic organization where reference back for further instructions can lead to endless delay. In my experience, governments by the nature of things are in a stronger position to settle a point around the conference table than the

⁴²*Medical Post*, June 20, 1967.

profession's leaders who may sometimes feel it wise to go back for further instructions. In this respect, there is no real comparison between Parliament and the governing body of a national association. Parliament has delegated far greater authority to government than the profession has so far to its elected leaders.

. . . I would like now to say a word about the somewhat esoteric relationship between the Minister and his principal advisors and those with whom he negotiates on behalf of the profession. In one sense both parties must be unyielding exponents of the cause they serve. In another sense some form of partnership if not overt must be developed if any measure of progress is to be achieved. Just the right degree of emphasis is not easy. Meeting round a table as we do regularly two or three times a week is not conducive to the taking of rigid stands. Indeed there can be a real danger of a too ready appreciation of the other person's point of view. Nevertheless I believe that it is possible to conduct negotiations in a friendly and cooperative atmosphere and that goodwill on both sides often secures more than acrimonious arguments held in a spirit of "no compromise at any cost".

Throughout this address I have had one thing close in mind. What advice would I give to a sister organization likely to be involved in the kind of protracted negotiations we in the United Kingdom have had for many years. The job of negotiation whether with Government or anyone else is to get what you want from someone who is not prepared — at any rate at the outset — to give all you ask for.

. . . The first essential is a strong association which can be seen to speak for a united profession. The second essential is to initiate and maintain the closest possible links with those who control public and parliamentary opinions. This includes the modern mass media of television and radio. The third essential is to gather the best possible team of advisors in the preparation of a case.

. . . Difficulties will always occur. They are inescapable when a Government nationalizes a liberal profession. But it must be the aim of both parties to keep talking round the conference table. Principles must remain sacred. But within their preservation there remains a wide area for discussion. Negotiations are an essential part of this process. They provide a challenge which we neglect at our peril.

These basic principles of cooperative action in a free and democratic society seem to us to be beyond question, and it is hard to see how men of goodwill — in politics and in the profession alike — can fail to respond to them.

Appendix VII

The Saskatchewan "Medicare" Crisis of 1962 — A Case Study¹

The controversy surrounding the introduction of the Saskatchewan Medical Care Insurance legislation presented aspects that were unique, up to that time, in the history of medical politics in English-speaking Canada. The first statements by Premier T. C. Douglas, in May and December 1959, that a medical care program was contemplated occasioned an atypical response on the part of the medical profession — it began to engage in massive public relations activity.

It may not be surprising that an environment which gave rise to Canada's most successful third-party movement also fostered a radically different form of medico-political activity. For in Saskatchewan socialist and "entrepreneurial" conservative philosophies coexist in an uneasy juxtaposition, and there exists at any time a substantial segment of the population which is basically antipathetic to the political philosophy of the group in power. Such a situation made it politically profitable for the medical profession to take its case to the forum of public opinion.

But it would be a mistake to view the Saskatchewan case as an example of pure pressure group activity. Although in its initial stages it may be so considered, in its later form it is more correctly viewed as a case of community conflict. A series of government blunders gave the profession a legitimate grievance, and provided the dissident rightist factions in the province with an issue over which to coalesce in opposition to the socialist government and to attempt to bring it down. By the time the doctors were prepared to withhold normal services to the public, the development of the classic syndrome of community conflict had precluded a "rational" and amicable settling of differences. What was begun as an attempt to influence a specific piece of legislation mushroomed into as bitter and pervasive a conflict as has occurred in Canadian politics.

The sequence of events may be briefly chronicled. A series of inquiries into the feasibility of extending existing prepaid health insurance schemes culminated

¹An edited version of an original paper by the author's research assistant, Miss Carolyn Hughes.

in Premier Douglas's proposal of December 1959 for a comprehensive medical care program in accordance with five basic principles:

- 1) prepayment
- 2) universal coverage
- 3) high quality of service
- 4) government sponsorship and administration by a public body responsible to the legislature
- 5) acceptability both to those providing the service and to those receiving it.

The College of Physicians and Surgeons of Saskatchewan had, at its annual conference in October, passed a resolution unanimously opposing the introduction of "a compulsory government-controlled province-wide medical care plan" and supporting "the extension of health and sickness benefits through indemnity and service plans". Hence a confrontation between the two sides was in the making. The first manifestation was occasioned by the creation of the committee upon whose proposals the legislation was to be based. The issues between the Government and the College involved the very composition and terms of reference of the committee. The College eventually conceded the inclusion of Douglas's "five principles" in the terms of reference of the committee, and the addition of Government employees to the membership. The Government, for its part, conceded the inclusion of one representative each from the Chamber of Commerce and organized labour as public representatives, but not their substitution for government employees, and also the express freedom of committee members from subscription to the five principles. On April 25, 1960, the Advisory Planning Committee on Medical Care came into being under the Chairmanship of Dr. W. P. Thompson, a noted biologist and former president of the University of Saskatchewan.

The June 1960 provincial election campaign was waged around the issue of medicare. The CCF, returned with an increased majority, regarded its victory as a mandate to continue with its medicare program.

In September 1961 the Thompson committee submitted an interim report. The division of feeling in the committee was evinced by its submission of three separate reports. The majority report recommended a universally applicable scheme of medical care insurance, to be financed partly by a direct premium imposed upon all self-supporting persons and partly by general tax revenues. Several of the proposals of the majority report were regarded as substantial concessions to the medical profession: the plan was to be administered, not directly by the Department of Health, but by an independent commission of not less than five and not more than seven members, including a chairman (preferably a physician) and at least two other physicians, plus the Deputy Minister of Health

as a non-voting member. Payment was to be on a fee-for-service basis; utilization fees were recommended to discourage over-use; and freedom of choice for doctor and patient was retained. Nonetheless, being a compromise, the majority report failed to satisfy the polar extremes represented on the committee — the College of Physicians and Surgeons, and the Federation of Labour. The College representatives, joined by the Chamber of Commerce representative, filed a minority report endorsing the recommendations put forward in the brief of the College: the subsidization of existing voluntary plans so that they might be extended, and the payment of premiums for low-income groups. Medical insurance, in other words, was to be universally available but not compulsory. The Federation of Labour, on the other hand, filed a dissenting report calling for a plan directly administered by the Department of Health, financed entirely by revenues from personal and corporate income taxes, involving remuneration by salary and not fee-for-service, and not providing for utilization fees.

On October 13, without having referred the Thompson report to the College, the Government introduced into the legislature the bill which was later to be passed as the Saskatchewan Medical Care Insurance Act. On November 28 the Council of the College refused to meet with the Government to discuss the implementation of the legislation on the grounds that this would involve "co-operation in a government-controlled medical plan" which had been expressly opposed at the conference of the College. In what may have been an attempt to provide a loophole whereby they could escape the bounds of the conference's categorical resolution, the Council did agree to meet with the government to discuss the "health needs of the people of the province". The Government refused to allow such a conference to take precedence over the Medical Care Insurance Act.

In the face of the College's opposition, the Government decided to take preliminary steps towards the implementation of the Act while leaving the door open for negotiations. On January 5, 1962, it announced the appointment of the members of the Medical Care Insurance Commission, only one of whom was a practising physician. The other two medical members were the Deputy Minister of Health (ex officio) and Dr. Samuel Wolfe² of the Department of Social and Preventive Medicine of the University of Saskatchewan. The College continued to refuse to meet with the Commission, despite repeated overtures, until it was forced to capitulate by the Government's ultimatum that March 28 was the last day on which amendment to the legislation could be considered. The College then agreed to meet with the Cabinet, but, significantly, not with the Commission.

During the negotiations on March 28, April 1, and April 11, the Government offered several amendments to the Act. The College rejected these on the grounds that the plan remained "government-controlled" and maintained, with minor

²An outspoken advocate of medicare, and, subsequently, joint author of an account of the crisis: *Doctors' Strike* (with Robin Badgley), *op. cit.*

modifications, the stand taken in its brief to the Thompson committee and the minority report of that body — the administration of a health insurance plan through approved voluntary agencies.

The amendments introduced into the legislature on April 13 included one giving the commission the power to act as the agent of the beneficiary and one effectively denying access to the courts in cases of "differences which may arise with respect to rates of payment under the Act". These amendments, it need hardly be noted, further antagonized the medical profession.

The College called a special general meeting in Regina on May 3 and 4. Following an address by Premier Lloyd, all but five of the delegates signified their intention not to cooperate with the Government. Further meetings between the College and the Government took place on June 22-24. Finally, the Saskatchewan Hospital Association, the Saskatchewan Association of Rural Municipalities, and the Saskatchewan Urban Municipalities Association arranged for a meeting between Premier Lloyd and Dr. Dalglish (president of the College)³ in a last-minute attempt to avert the crisis. At all these meetings, the Government offered to make substantial alterations in the Act (short of the College demand for operating through approved voluntary agencies) through regulations which were to be solidified in legislation to be introduced in the next session of the legislature. The College, however, continued to insist upon a complete rewriting of the Act, and the negotiations ended in stalemate.

On July 1, 1962 the Saskatchewan Medical Care Insurance Act went into effect. About thirty doctors began to practise under the Act, and approximately 225 others staffed the emergency centres set up by the College, working gratuitously rather than accepting payment from the Commission.

On July 14 Dr. Dalglish indicated the College's willingness to renew negotiations and resume normal practice on the condition that the Act be suspended for a specific length of time and that a special session of the legislature be called. The Government agreed to call a special session of the legislature but refused to suspend the Act. Finally, Dr. Dalglish, addressing the annual convention of the CCF-NDP, called for a renewal of negotiations without the condition of suspension. Through the mediation of Lord Taylor, a British Labour peer and physician called from Britain by the Saskatchewan Government as a conciliator,⁴ the College and the Government reached an agreement, signed in Saskatoon on July 23. The schedule of amendments agreed to was enacted at a special one-day session of the legislature on August 2.

³President of the CMA in 1968.

⁴Now Chancellor of Memorial University, Newfoundland.

The above chronology does not reveal the development of the issues involved in the conflict between the CCF Government and the College of Physicians and Surgeons. The basic issue between them was the fear expressed in the October 1961 resolution of the College — the doctors' fear of a "government-controlled medical plan". In other words, the doctors feared that the Government intended not just to administer a medical insurance scheme, but effectively to control the provision of medical services in Saskatchewan; the task of the Government was, in deeds as well as in words, to allay these fears. A series of blunders on the part of the Government and political opportunism on the part of a dissatisfied segment of the population, however, served only to exacerbate these fears, until a mutual distrust had virtually closed the minds of both sets of protagonists to negotiation.

The first bungle was the precipitous introduction of the Medical Care Insurance bill into the legislature only twenty-one days after the receipt of the Thompson report, and without having referred the report to the College for detailed criticism. It has been suggested that the members of the Cabinet doubtless felt that they knew what attitude would be taken by the College. In the face of the vigorous anti-medicare campaign waged by the College during the 1960 election and the difficulties in agreeing on the terms of reference and the composition of the committee, this allegation is probably true. But it is likely that political expediency played a larger part in the decision to rush the legislation through. T. C. Douglas was to leave the provincial premiership on November 7 to assume the leadership of the federal CCF-NDP. Due to the large labour component in the federal party, it was essential that Douglas have a record of welfare legislation, and the introduction of the first comprehensive medical insurance scheme in North America under his auspices would greatly enhance his position as federal leader. Another political consideration which could have influenced the precipitous introduction of the bill may have been the desire to have the medicare plan which Douglas had promised fully functioning and "de-bugged" for public evaluation by the time of the next provincial election. Whatever the reason, the Government's action served to confirm the fears of the doctors that government regulation would subject the practice of medicine to the vagaries of politics, and reinforced the position of the extremists within and without their ranks.

Not only was the Medical Care Insurance bill ill-timed, it was also ambiguously and badly worded. E. A. Tollefson, author of *Bitter Medicine*,⁵ admits this, but claims that the doctors had given the Act "the most perverse interpretation possible" and that their failure to "give the Act a reasonable interpretation and to distinguish possibility from practical probability in its implementation" was "a failure to understand how our courts operate in construing the law". Indeed it is highly unlikely that the powers which the doctors inferred from the Act would

⁵E. A. Tollefson, *Bitter Medicine*, Modern Press, Saskatoon, 1963.

ever have been exercised, but the fact remains that (through poor draftsmanship) they existed on paper; and the College, having once been ignored by the Government, was in no frame of mind to allow it the benefit of the doubt.

Fearing that economic control could easily lead to total effective control of the practice of medicine in the province, the doctors took strong exception to the provisions which allowed the Commission wide discretionary powers. The most objectionable provision in this respect was Section 49.1.

Subject to the approval of the Lieutenant Governor in Council the commission may make regulations for the purpose of establishing and administering a plan of medical care insurance for the residents of Saskatchewan, and without restricting the generality of the foregoing, may make regulations:

(g) prescribing the terms and conditions on which physicians and other persons may provide insured services to beneficiaries.

(i) respecting the maintenance and improvement of the quality of the services provided under this Act, to the end that the highest possible standards of service will be achieved.

Apart from such blanket authority, the Commission was also given specific powers to "provide for the establishing, maintaining, and altering (subject to consultation with the professional association) of a list of persons entitled to receive payment under this Act for the provision of insured services", and to designate which of these were to be termed "specialists". Finally, the Act gave the Commission power to make regulations "prescribing the rates of payment to be made under this Act to physicians and other persons and the method of assessing accounts submitted by physicians and other persons". No provision for the *negotiation* of rates was made; even if negotiations were allowed, the Commission, through the Cabinet, had the ultimate power to enforce its views.

The mistakes of timing and of wording did not cease with the introduction of the Act. Perhaps the frustration engendered by the intransigence of the medical profession produced among Government officials the feeling that they might as well be hung for sheep as lambs. At any rate, the amendments which were introduced on April 13 could only have been expected to arouse further the ire of the profession. Most offensive was Section 28(a) which provided that the Commission would act as the agent of the beneficiary, and which was construed by the medical profession as enabling the Commission to sue a doctor to recover any sum paid him by the Commission on behalf of the beneficiary, on the ground that it was paid under a mistake of law of fact. Such a construction, while highly improbable, was nonetheless permitted by the poor wording of the legislation. Badgley and Wolfe declare that in this instance the Government acted "unwisely, angrily, and against many of its own advisors".⁶

⁶Robin Badgley and Dr. Sam Wolfe, *op. cit.*

The concessions offered by the Government in late June would have removed much of what the doctors found objectionable in the Act. As E. F. Tollefson reports:

In particular the Government was willing to repeal the provisions relating to the establishment of a medical advisory committee, the portion of Section 43 which imposed a penalty for failure to submit a report, and clause (g) of Section 49.1. relating to the Commission's power to make regulations prescribing the terms and conditions on which physicians and other persons might provide insured services to the beneficiaries. The Government was also willing to repeal the agency provision, Section 28a (1) and (2) if the profession would undertake not to discriminate against beneficiaries seeking services under the plan. The Government was willing to re-draft provisions relating to the definition of the word "physician", the power of the commission to act, the number of members on the advisory council, the list of those entitled to receive payment, and the methods of payment and the appeal procedure.⁷

More significant than any of these offers, however, was the offer to reimburse beneficiaries at 85 per cent of the College's schedule of fees for bills received directly by the beneficiary from the doctor, in effect allowing the doctor to practise without any direct contact with the Commission — in fact, without any contact whatsoever should the patient decide not to apply to the Commission for reimbursement.

Perhaps these concessions would have been accepted at an earlier date by the College. But by the end of June, as we shall see, misunderstandings and outside forces had raised the emotional tone and mutual distrust of the protagonists to such a level that the profession could reject these offers as idle promises which might not be enshrined in legislation, and maintain that the Act remained a "device to control" and not an insurance mechanism. A College newsletter (June 27, 1962) reports the June discussions as follows:

At the initiation of discussions Council (of the College) presented four items:

- 1) Government's acceptance of the principle of acceptability to those rendering services.
- 2) A delay in the implementation of the Act on July 1; and until such time as an Act and plan could be devised, acceptable to both Government and the profession.
- 3) Multiple carriers rather than a single monopolistic government carrier.
- 4) Mechanisms by which changes in the Saskatchewan Medical Care Insurance Act could be accomplished.

There was no acceptance of the first three items — and no satisfactory answer was given concerning changes in the Act.

The phrase "no satisfactory answer was given" conceals a host of grievances. The College complained that its six-page document "Criticism of the Act" (the

⁷E. F. Tollefson, *op cit.*

first such detailed criticism submitted and an encouragement that the Act would not be rejected out of hand) was "tabled and not discussed, due to pressure on the part of the Cabinet to attempt to gain acceptance by Council of the principle of reimbursement". Concerning this principle the College Council replied:

Our legal advisors doubt whether this can be legally done under the present Act, *which still remains unchanged*. Doctors, patients and medical services would be divided into two groups; which is undesirable to Government and to the profession.

This eleventh hour proposal . . . was given in insufficient detail to permit a proper presentation to the profession for their decision.

Furthermore, *no legislative security is afforded by the Government's verbal offer*.

The Saskatoon Agreement, reached on July 23, 1962, incorporated all of the concessions offered by the Government in the June negotiations, plus the further concession that private carriers were to remain in existence. This was crucial from a psychological, if not from a practical, standpoint; for the demand for the continuance of private carriers had been a basic tenet of the College's position throughout the dispute. Since the agency and not the Commission acts as the agent of the beneficiary, the doctors now feel secure from the threat, however distant, of arbitrary reclamation of payment by the Commission on behalf of the beneficiary. (Despite the repeal of clause 28(a), the Commission as an insurance agency could still act as the agent of a beneficiary not registered with a voluntary agency.)

The Saskatoon Agreement spelled out four possible avenues of reimbursement:

- 1) If either the doctor or the patient or both do not belong to one of the voluntary carriers:
 - (a) the doctor may bill the patient directly, and the patient may then:
 - (i) pay the bill directly from private sources or
 - (ii) submit the bill to the Commission for reimbursement at 85 per cent of the College's fee schedule, being personally responsible for the remaining amount of the bill.
 - (b) the doctor may bill the Commission directly for services rendered to the patient and accept payment from the Commission at 85 per cent of the College's fee schedule as payment in full.
- 2) If both patient and doctor belong to one of the private plans, the doctor will submit his bill to the agency at 85 per cent of the College's fee schedule and will accept this amount as payment in full. The agency forwards the bill to the Commission, receives payment, and pays this amount to the doctor.

It has been charged that the private carriers are uselessly costly "psychological buffers" and are no more than mail clearance houses forwarding bills and payment. Be this as it may, in the present situation they guarantee the patient's free choice of doctor. Without the private carriers, the patient who chose a doctor not

enrolled with the Commission (and only a minority are so enrolled) would be liable for payment of his bill above the 85 per cent of the College schedule for which he could be reimbursed by the Commission. The agencies guarantee that the doctor will accept the 85 per cent Commission reimbursement as payment in full while providing a mechanism of reimbursement which the doctors consider legitimate and non-threatening. Without legitimacy, no political system or part thereof can function effectively, and it is not always to be sacrificed to economy. In addition, for a further premium, the voluntary agencies provide coverage for services not covered by the Medical Care Insurance Act.

The Agreement also contained proposals for an arbitration commission to be set up if negotiation between the College and the Commission concerning the fee schedule or the percentage of remuneration failed. However, on July 27, the College issued a Supplementary Memorandum to the Saskatoon Agreement "to correct an error resulting from the haste, pressure, and stress under which the agreement was drafted and not from any lack of good faith by either party". It denied that agreement had been reached that "resort should be had in any way to arbitration". This leaves any change in the schedule or percentage to be achieved through negotiation, and constitutes a further victory in the eyes of the profession.

Such were the specific issues in the conflict. It remains to consider the participants themselves. Neither the government nor the profession constituted a monolithic entity, and fissures within each weakened the pressure which they could bring to bear. Each could command different types of resources in the conflict, and the differences influenced the tactics to which each had recourse. The Government could claim both a "mandate from the people" and a "monopoly of legitimate force". But it had been elected by less than a majority of the population, and the Liberals (who had received 33 per cent of the popular vote) were vociferous in their opposition to the plan. Both Government and Opposition members voted in favour of the bill on second reading (approval in principle) but after a stormy debate the Opposition members voted against it on third reading. Opposition leader Ross Thatcher outlined his party's reasons for its stand: probable refusal of the doctors to cooperate, "staggering costs", the tax burden, and the probable loss of "many of Saskatchewan's best doctors" which the bill would occasion. The vote on the April amendments also divided along party lines. Throughout May, June and July, the Liberals continually demanded that a special session of the legislature be called to deal with the crisis, and on July 11, Thatcher staged a dramatic attempt to open the legislature by attempting literally to break down the door. As will be discussed below, the opposition parties were extremely active in the "Keep Our Doctors" committees.

Even within the CCF itself there were differences of opinion. Woodrow Lloyd, taking over the office of Premier from Tommy Douglas, replaced J. W. Erb with William G. Davis, a long-time trade-union activist, as Minister of Health.

The profession took this as an indication of a growing influence of the left in the CCF. Mr. Erb resigned from the Government on May 3, the first day of the doctors' mass meeting, citing "reasons of principle". His resignation was made known to the meeting during Premier Lloyd's address, and provided the profession with a choice piece of propaganda. He later joined the Liberal party, ran as a candidate, and was defeated; but some time after he was appointed head of the Workmen's Compensation Board by the new Liberal government.

One factor of crucial importance for the development of the controversy was the change in leadership from Tommy Douglas to Woodrow Lloyd. While Douglas was known to be a high-powered politician who was prepared to fight to introduce medicare, Lloyd presented a quiet, unassuming aspect and was reputed to want to avoid a bitter struggle at all costs. Throughout the controversy, he pleaded for calm, even in the face of opposition from medicare supporters who criticized his "strategy of silence". This division in the CCF ranks, between those who supported Lloyd's moderate, conciliatory stand, and those who wanted an out-and-out fight with the medical profession, may have contributed to the vacillating tactics of the Government from March to June, alternating between conciliatory overtures such as the concessions proposed in late March and in late June, and "get tough" measures such as the April amendments. This vacillation was of no little significance, according to Commission Chairman Donald Tansley:

... if the government had made it possible for doctors to operate "outside the plan" as was done in the amendments to the regulations in late June, much of the opposition might have crumpled in May or June. The government may have changed its position too frequently from April to July. I am sure this gave the profession the impression from time to time that the government was weakening.

The Commission was in favour, in late April and throughout May and early June, of making it quite clear publicly that we were prepared to bring doctors in from overseas to supply services if necessary. The government did not really agree even to the recruitment of doctors on the quiet until late June. On the whole, I think, the Commission kept the objective much more clearly in mind than the government.⁸

The College of Physicians and Surgeons of Saskatchewan could claim neither a popular mandate nor a monopoly of legitimate force, but it could claim to speak for its entire membership (i.e., all the doctors in the province) with little fear of sizable dissent. It constituted both the licensing body and the professional association; hence it is claimed that it held an effective monopoly of policy statements by doctors, and that considerable courage would be required on the part of the physician who openly dissented from the body which held the power to revoke his licence to practise. But it is questionable that Saskatchewan doctors were any more or any less inhibited from expressing their policy views than they would have been had the professional association been distinct from the College, for

⁸Quoted in Robin Badgley and Dr. Sam Wolfe, *op cit.*, p. 100.

the sanctions employed against doctors who expressed pro-medicare views and who ultimately chose to practise under the Act were not applied by the College as an organized body. No licences were revoked; indeed the "strike-breaking" British doctors were licensed by the College under its reciprocity agreement with its British counterpart. Rather the sanctions were social ostracism, refusals to refer patients or to accept referrals from "mavericks", and, most commonly, curtailment of hospital privileges by hospital committees. Even after the crisis these sanctions continued to be applied to doctors who chose to engage in community clinics. The sanctions, in other words, were applied by doctors at the local level and not formally by the College *qua* statutory licensing body.⁹

Leaving aside the question of sanctions, however, it must be admitted that the College attempted to exercise tight control over the policy statements of its members. In a newsletter dated February 19, 1962, the Council announced:

The Government's compulsory state-controlled Medical Care Plan, its Commission, and the doctors' opposition, will undoubtedly receive much attention. There may be some heated political discussion and statements. We would urge you to refrain from discussing controversial matters publicly. The views of the Medical Profession as presented in the Saskatchewan Profession's brief to the Royal Commission have been sent to all members of the legislature.

Furthermore, on May 11, 1962, a newsletter announced:

In view of the political campaign now in progress for the Federal election, and the recent evidence of more attempts to engage the profession in political debate, your Council *urges* you to refrain from any public activities in this regard.

Statements that are deemed necessary will be issued by spokesmen of the College.

Enclosed in the same newsletter was a copy of a radio address prepared by the College with the comment:

As a result of a resolution passed at the Special General Meeting and realizing that insufficient information has been supplied to the public concerning the doctors' stand, a fifteen minute radio address was prepared and has been presented through the medium of television and radio throughout the province by local doctors. A copy is enclosed for your information.

The prepared address, it must be noted, was commendably lacking in the sort of hysterical tone that characterized the releases of the "Keep Our Doctors" committees and other anti-medicare groups. The predominant theme was that the Medical Care Insurance Act went beyond the provision of insurance to control the provision of medical service, and that there would be no patient-doctor contact outside the Act.

⁹Such an attempt on the part of the College would probably have been unlawful — i.e., *ultra vires*?

Whether a separate Saskatchewan Medical Association would have taken a stand different from that of the College must remain an open question, but this appears unlikely in the light of factors to be discussed below tending to weld the doctors into a beleaguered unity. The authority of the Council of the College seems to derive more from the nature of the profession than from its statutory powers. The doctors were highly disposed to accept the decision of the majority of their colleagues and to give the Council of the College, as the spokesmen for the majority, wide discretionary powers in handling the dispute. The social factors predisposing doctors to subscribe to a highly individualistic view regardless of its espousal by a representative professional body have been discussed elsewhere (for example in Chapter 16) and need not be reiterated here.

Whatever the reasons, dissent within the profession was minimal. Thirty of the province's 725 practising doctors agreed to work under the plan. Only one practising doctor could be recruited to serve on the Commission. Members of the faculty of the University of Saskatchewan, the Government's only anticipated locus of support within the profession, officially maintained a neutral position, and Badgley and Wolfe cite examples of sanctions imposed by members of the faculty against others who showed pro-medicare sentiments. A letter written over the signature of Chairman Tansley to each doctor in the province occasioned an avalanche of irate and sometimes unbelievably intemperate mail from the recipients.

The dispute, then, involved a Government on rather shaky electoral ground and undergoing a change both in personnel and style of leadership, confronted by an organization possessing statutory and, more important, social control of its members. To this extent, the conflict assumes the aspect of a case of pressure upon a government through the public relations activity of a well-organized pressure group. And indeed, in the early stages, notably during the 1960 election campaign and the period immediately following the introduction of the legislation, this was a fair characterization of the situation. What factors led to the increasing intransigence of the medical profession and to the escalation of the conflict beyond the medico-political arena into what appeared to become a challenge to the foundations of parliamentary democracy?

Government blundering, and its image of arbitrariness, indecision and weakness, has been given some consideration above. The doctors were more likely to support an extreme stand taken by the College Council the more government blunders appeared to bear out the College's fear of arbitrary action.

But much of the responsibility for the escalation must be attributed to the opposition parties. The same lack of consensus that fostered the use of public relations tactics by the College is even more evident in the later stages of the conflict. The medicare legislation appears to have been regarded by most conservative elements in the population as a beachhead upon which to mount an all-out invasion against the "socialist" policies of the CCF Government, with the object of bringing about the Government's defeat. The most obvious examples

of this coalition of forces, of course, were the "Keep Our Doctors" committees. These were supposedly spontaneous organizations of the citizens of various localities working for the repeal of the Medical Care legislation, and began as committees of housewives concerned about the impending loss of medical services. Their chief tactics were the holding of public meetings and the publication of anti-medicare literature and press releases. Soon, however, according to Badgley and Wolfe, "mothers and housewives unintentionally became a front for business and professional men, politicians, and doctors". Among the politicians, of course, the Liberals numbered heavily. In fact, many government supporters and others claimed that the KOD committees became organs of the Liberal party, where Liberals could engage in more virulent denunciation of the CCF Government than they could within the constraints of party politics within a parliamentary democracy. The tactics used by the KOD were those calculated to attract the widest degree of public attention: posters and placards, press releases, motorcades, and public rallies. The most spectacular of the latter was to be the rally called at the legislative buildings on July 11. Although only 4,000 of the expected 30,000 to 40,000 marchers appeared, the spectacle of Ross Thatcher, backed by an angry mob, kicking at the door of the legislature could only further aggravate the atmosphere of tension. The themes to which the KOD committees appealed throughout the conflict — anti-Communism, individualism, and the fear of lack of recourse to medical aid in the face of a threat to health or life itself — were highly emotional and irrational and resulted, whether or not by design, in the development of a mentality scarcely amenable to negotiation. Threatening letters and telephone calls were received by government officials and doctors working under the Act. (It is impossible, of course, to attribute these firmly to the KOD committees or to any other organized group.)

The atmosphere of emotionalism was fostered by the Saskatchewan press. In a speech delivered as part of a panel discussion at the conference of Canadian Managing Editors in 1963, Allan Blakeney, Minister of Public Health for Saskatchewan, discussed the coverage of the conflict by the Saskatchewan press, notably the Regina *Leader-Post* and the Saskatoon *Star-Phoenix*. He cited instances, not only of adverse editorial comment, but of "distorted emphasis . . . sensationalism . . . suppression of news . . . omission of relevant material . . . carelessness and retractions" in both these papers, to the detriment of the pro-medicare forces and in support of the doctors and the KOD committees. The College was quick to call attention to, and even to republish in its newsletters, editorials supportive of the doctors' position. The press outside Saskatchewan, according to Mr. Blakeney, almost universally condemned the medical profession in its editorials and gave a more balanced coverage of events. A quick survey of editorials and reports in the Toronto *Globe and Mail*, the Toronto *Daily Star*, and the Winnipeg *Tribune* seems to bear this out. The Saskatchewan doctors and press, of course, maintain that this point of view stemmed from the outsiders' inadequate acquaintance with the facts. Such support from within the province and opposition

from without was a potent factor in reinforcing the doctors' self-definition as a beleaguered bastion of individual rights.

The doctors of Saskatchewan were led to believe that they enjoyed the support not only of the people of the province, but of the medical profession as a whole. The Canadian Medical Association and its branches gave the doctors financial and moral support throughout the crisis. The CMA donated \$35,000 to the College's campaign against medicare in the 1960 provincial election campaign. At its annual meeting in June 1960, the Association declared that a "tax-supported comprehensive program, compulsory for all, is neither desirable nor necessary", and outlined fourteen principles with which a plan would have to comply in order to be acceptable to the CMA. At its June 1962 annual meeting, just prior to the Saskatchewan "strike", the CMA expressed its unanimous support for the resistance of the Saskatchewan doctors to the plan, although it was not unanimous in its feeling concerning the "moral implications involved in a mass closure of physicians' offices". When the strike came, the CMA helped to relocate the doctors who left Saskatchewan, but softened its previous stand that the Medical Care Insurance Act be repealed to a demand that it be suspended until a satisfactory agreement could be reached. Even after the Saskatoon Agreement, the CMA, like the Saskatchewan College, continued to oppose the plan. In December 1962, Dr. MacCharles, then president of the CMA, declared that the plan was doomed, and that 90 per cent of the people of Saskatchewan had supported the doctors. CMA provincial branches were vociferous in their support of the Saskatchewan doctors. In particular, the Ontario Medical Association issued a newsletter on July 12, 1962, strongly supporting their stand, and established a "Saskatchewan Aid Fund" to give financial as well as moral assistance. A letter received by the general secretary of the OMA from the president of the Ottawa Academy of Medicine reflects the mood of many Ontario doctors:

I am sure that the vast majority of the doctors of Ontario are fully behind such a request (for contributions to the fund). I have talked to some of the members of our Academy and the suggestion has been made that the Ontario Medical Association place the \$25,000 in the fund immediately and collect donations from the members of the OMA later. In this way financial aid can be given now. The topic is ripe now! The urgency is now! They need the lift to their morale now! Let's show them that we appreciate the fight that they put up for *us* now!

In summary, then, the doctors were faced with a Government whose vacillation gave the appearance of weakness, by increasing evidence of government carelessness of their interests, by strong and vociferous support from the local press and from the national and provincial associations of their profession. In this context it is not surprising that their opposition to the plan and their determination to see the conflict through to a successful conclusion hardened. But more important was the increasing participation in the doctors' cause of a number of political opportunists and dissident elements in the population who sought not the repeal of a specific piece of legislation, but the defeat of a government. The statements

of the College itself were relatively moderate and confined to a denunciation of the Medical Care Insurance Act and the tactics of the government in dealing with the College on this specific issue. Through the participation of these other groups (formalized in the "Keep Our Doctors" and Conservative-inspired "Save Our Saskatchewan" committees) these relatively moderate statements were swamped in a wave of reactionary, anti-Communist hysteria, as exemplified in the radio address of Father Murray quoted at length in Badgley and Wolfe's account and reminiscent of the fulminations of Father Coughlin against the New Deal during the 1930's in the American Mid-West. Although the College's appeals to its members to refrain from public activity and to leave the handling of the crisis to the Council have been cited as evidence of its control over the policy views of its members, it may also rightly be viewed as an attempt to keep doctors from making the sort of hysterical public pronouncements associated with the KOD committees.

As the strike progressed in July, the factors tending to fortify the doctors in their resistance to the plan began to change. As the Government appeared able to maintain emergency services with doctors recruited from outside the province, it became evident that the Government would not crumble before the doctors' ultimate weapon. The monolithic structure of the profession began to crack as doctors who continued to oppose the plan but who, ethically, felt they could not countenance the strike began to make their dissent known. Not the least of these was Dr. Allan Bailey, professor of medicine at the University of Saskatchewan, who was quoted in the *Toronto Globe and Mail* as opposing the strike as unethical and illegal, and urging doctors to practise without enrolling with the Commission and to work for compromise. Suggestion of decreasing support from the profession outside the province also began to appear. The CMA modified its demand for the repeal of the legislation, instead demanding its suspension pending the reaching of an agreement. *The Lancet* and the *British Medical Journal* condemned the strike as unethical. Finally, although the KOD committees continued their vitriolic campaign, their poor showing at a mass rally on July 11 (4,000 demonstrators out of an anticipated 30,000) revealed that their support was much less than the noise they were making implied. Faced with these reversals in the image of their crusade, and with the consequences of their decision, the doctors determined to go to the negotiating table.

It is not surprising, indeed it is to be expected, that the activities of a pressure group will attract supporters from outside its ranks. But the distinguishing feature of the Saskatchewan case is that these outsiders, interested not in a particular piece of legislation but in the defeat of a government, came to exert a greater influence upon the course of events and the tenor of the campaign than did the members of the pressure group themselves. The atmosphere of hysteria they whipped up, the vociferous and virulent condemnations of the government, and the dire predictions of communistic doom, could only confirm and augment the doctors' fears of the Medical Care Insurance legislation and inflate their concept of the support which they enjoyed in the province. By the time the vast majority

of doctors in the province were prepared to follow the decision of their leaders to strike, the blame for this abnegation of social responsibility and of the methods of parliamentary democracy was shared to an equal or greater extent by a political opposition who had capitalized on the legitimate grievances of a group carelessly treated by government.

The medical profession in Saskatchewan has continually reiterated its opposition to the Medical Care Insurance Plan, but with a decreasing vehemence. *Globe and Mail* reporter Joan Hollobon visited Saskatchewan in December 1962, after the plan had been in operation for six months, and returned to report a continuing hostile atmosphere, with both sides charging obstruction. The Government charged that pro-medicare doctors were denied or made to wait for hospital privileges; the College countered with the charge that anti-medicare doctors were threatened with replacement by pro-medicare doctors working in government (or at least CCF) supported Community Health Clinics, and further charged that the Commission delayed payments to doctors practising outside the scheme. The Government denied sponsorship of the Community Health Clinics and claimed that any delays in payment were due to the uncooperativeness of the doctors or to their desire to use the time-consuming route of dealing through the voluntary agencies. In reviewing the crisis in a newsletter dated July 23, 1963, the College stated:

The policy of the profession is still the recommendation in our brief presented to the Thompson Commission two years ago and to the Royal Commission on Health Services one year ago

Your Council hopes that the Medical Care Insurance Act has been reduced to an insurance agency. The Commission is functioning now, doctors' bills are being paid promptly We do not need to remind you that the greatest right re-established July 1962 was the ability of the patient and the doctor to be outside the Medical Care Insurance Act.

There can be no satisfactory solution to the medical care problem as long as it remains in the political arena. We can only hope that political leaders . . . will not use medical care as a road to political power and will work out a solution in the absence of partisan politics Unless (this) happens it is inevitable that there will be strife and mistrust for a long period of time.

With the defeat of the CCF Government in 1964, much of the legacy of bitterness between the profession and the government was dispelled, and a much more conciliatory atmosphere has prevailed. Upon the appointment of Dr. R. G. Murray, professor of ophthalmology at the University of Saskatchewan, as Chairman of the Medical Care Insurance Commission, the College announced that:

Congratulations are in order to Dr. R. G. Murray on his appointment as Chairman of the Medical Care Insurance Commission—the first time a physician has been named to this important post. Council is extremely pleased with this appointment and have found it much easier now to communicate with the Commission and help it resolve mutual problems.

In its November 20, 1964 newsletter, the College took a much more conciliatory stand towards medicare, virtually accepting the existing plan as a *fait accompli* which the profession must cooperate with government to improve:

Most of the predicted disadvantages of state medicine have already been demonstrated by the brief operation of the Medical Care Insurance Plan. We believe that the complete answer to medical care *with or without* government assistance and control has yet to be found. (The abuses involved in the plan) can be permanently corrected only by a change in the concept of the plan. The fact remains, however, that this present plan is now in effect. It behoves us to make improvements and corrections in its operation To do this we require cooperation from the government, the M.C.I.C., the Profession, and the Public.¹⁰

Joan Hollobon quotes Dr. Barootes, president of the College, as saying in 1965 that the College must be realistic and pragmatic and accept the existing system. The College has been cooperating with the Commission by passing directives from the Commission concerning Commission regulations to the profession through its newsletters. But it still remains firmly in favour of dealing directly with the patient in matters of billing, maintaining that in this principle lies "the ultimate preservation of the profession's freedom". As a second choice it recommends dealing through one of the approved voluntary agencies, despite the increased correspondence this may require. As far as the general membership is concerned, no convincing survey of their reaction to medicare has been made; but Dr. W. P. Thompson (of the Thompson Commission) circulated a questionnaire among members of the College in 1965 asking whether, in a secret vote, the recipient would vote for a continuation of the present scheme or a return to the pre-1962 situation. It must be noted that the questionnaire provided no other alternatives and that it was followed by a letter from the Council of the College requesting any who answered the questionnaire to inform the College of their views also! One-third of the recipients returned the questionnaire and two-thirds of this number supported the existing scheme. Hence at least two-ninths of the physicians (approximately 220) appeared to be basically content with the plan — a considerable increase from the thirty who were openly prepared to work under it in 1962.

Relations between the profession and the government, of course, have not been without conflict since the reaching of the Saskatoon Agreement, although, as noted, they have been more harmonious since the assumption of power by the Liberal party. The most acrimonious disputes have centred around diagnostic services and Community Clinics.

Community Clinics were centres organized by lay groups offering physicians facilities to practise in a particular locality provided they were enrolled with the Commission (i.e., submitted their bills directly to the Commission and accepted

¹⁰Emphasis added.

payment by the Commission as payment in full). The College claimed that these clinics were "centrally directed and politically (i.e., CCF) inspired". The doctors enrolled with such clinics claimed discrimination on the part of the hospital boards. In 1963 the complaints reached such an extent that the CCF government appointed Judge Mervyn Woods as a one-man commission to look into their causes. The Woods report found reason to suspect discrimination against Community Clinic doctors and recommended the establishment of an appeal board to review denials of hospital privileges. The CCF passed legislation to this effect, ensuring that a majority of the Board would be physicians nominated by the College. The College, however, opposed the legislation and refused to nominate members. The Liberals, on taking office in 1964, revoked the CCF appointments to the Board and after negotiating with the profession agreed to repeal the legislation (for which they had voted) on the condition that the College undertake to ensure non-discrimination. The College then set up a Professional Review Committee which appears to have been a successful solution to the problem.

Appendix VIII

The Ontario Council of Health

The Ontario Council of Health was set up by an Order-in-Council of June 16, 1967. The creation of a body to coordinate and plan the health services in Ontario followed the recommendation of the Royal Commission on the Health Services (the Hall Commission) that:

. . . to ensure democratic participation in the setting of goals and objectives . . . provincial Health Planning Council(s) should be appointed by the provincial government(s) from panels nominated by professional bodies (and) voluntary organizations

The Council is composed of a Chairman (the Deputy Minister of Health), five members representing the key health professions (the OMA and the College share one member), five members representing public voluntary bodies, five members appointed "for their expert knowledge in important fields", and the Chairman of the Ontario Hospital Services Commission *ex officio*. It was intended that the Council should "have balance with regard to expert knowledge, experience, and a reasonable geographical distribution".

The first members were (apart from the Deputy Minister, Dr. Charron, and the Chairman of OHSC, Mr. Martin): Dr. Ian MacDonald of the University of Toronto's Department of Continuing (Medical) Education, representing the College of Physicians and Surgeons, and the OMA; Dr. W. J. Dunn, representing the Royal College of Dental Surgeons of Ontario and the Ontario Dental Association; Mr. F. A. Wilson, representing the College of Pharmacy and the Ontario Pharmacists Association; Miss Catherine Aikin, representing the College of Nursing and the Registered Nurses' Association of Ontario; Mr. G. W. Phelps, representing the Ontario Hospitals Association; Dr. R. M. Anderson (a medical doctor, but nominated by the Chamber of Commerce); Mr. Harry Simon of Toronto, representing organized labour; Dr. M. R. Richards of the Ontario Agricultural College, Guelph; Mr. R. Auld of Toronto, representing voluntary health agencies; Mrs. R. E. Smart of Ottawa, President of the Ontario Mental Health Association, representing women's interests; Dr. G. E. Hall, the President of the University of Western Ontario; Dr. J. Fraser Mustard, representing medical research; Dean E. H. Botterell, Dean of Medicine, Queen's University, representing the Association of Canadian Medical Colleges; the Rev. Dr. H. L. Bertrand, S. J., from Sudbury, representing Northern Ontario, French-speaking Ontarians, and hospital admin-

istration; and Dr. Oswald Hall of the University of Toronto, a distinguished sociologist with a special interest in the health services.

The Council is the senior advisory body on health matters to the Minister of Health and the Government of Ontario. In particular, it is required to advise upon:

- 1) The coordination of the health services.
- 2) Techniques for long-term planning.
- 3) Priorities and phasing.
- 4) Health resources development, including the resources needed for education and training, services, and research.
- 5) Health manpower requirements.

The Council has set up a number of committees, and it has an Executive Director. It is backed by the resources of the Research and Planning Branch of the Department of Health.

The Ontario medical profession is well represented on the Council and its committees, though its formal representation is confined to one of five members "representing key health groups". The head of the Research and Planning Branch of the Department of Health is an *ex officio* member of all committees, but the Branch is not formally part of the Council structure and it can conduct research on its own initiative.

Among the important committees that have been created are a committee on health manpower (chaired by Dean Botterell), one on education of the health disciplines, one on physical resources, one on the regional organization of the health services, one on research, one on health statistics, and one on library services. Many of these committees have set up subcommittees to study particular aspects of their remit. Members of the committees and subcommittees are drawn extensively from outside the Council membership, and this pulls into the Council structure a number of other medical doctors; but they are appointed for their particular expertise and not for their representative character (i.e., the fact that they are members of the OMA or the College). However, there appears to be good liaison between the Council and its committees, and the various representative bodies in the health field.

The structure of the Department of Health itself is still very much that of a "public and environmental health" department; and there are major branches for Mental Health (all mental hospitals are, of course, run by the government), and for Public Health. The very large Medical Services Insurance Division was added when the Ontario Medical Services Insurance Plan came into being. The Research and Planning Branch reports directly to the Minister and his Deputy.

It is clear, however, that the responsibility of the Minister and his Deputy extends over the whole field of health services. That is to say, their responsibilities go far beyond mental and public health and medical services insurance.

Certain independent agencies stand in special relation to the Department: the Ontario Hospital Services Commission, the Alcoholism and Drug Addiction Research Foundation, the Ontario Mental Health Foundation, the Ontario Cancer Treatment and Research Foundation, and the Ontario Cancer Institute, all of which receive substantial support from public funds.

Appendix IX

Chronology of Major Landmarks in the History of Organized Medicine in Canada¹

- 1824 Establishment of first medical school in Canada (became Faculty of Medicine, McGill University).
- 1826 First medical societies established. Founding of first Canadian medical journal (*Journal de Médecine de Québec*).
- *1833 Formation in the town of York (later Toronto) of the Medico-Chirurgical Society of Upper Canada.
- *1843 Faculty of Medicine founded in King's College, Toronto.
- 1845 First recorded discussions on the formation of a national medical association in Canada.
- 1847 Embryonic national medical association (forerunner of CMA) established.
- *1853 Faculty of Medicine, Toronto, abolished though university continued to grant medical degrees.
- *1854 Medical Faculty established at Queen's University.
Foundation of Medical Society of Nova Scotia (now a Division of the CMA).
- 1855 Prince Edward Island Medical Association founded (now a Division of the CMA).
- 1862 Publication of the first issue of the *Canadian Lancet* (ceased publication in 1922).
- 1864 Foundation of the *Canadian Medical Journal and Monthly Review* (forerunner of the *Canadian Medical Association Journal*).
- *1866 Queen's Medical Faculty reorganized as the Royal College of Physicians and Surgeons, but affiliated with the University.
First Act incorporating the medical profession of Ontario.
- *1867 Inaugural meeting of the Canadian Medical Association. First Canadian woman doctor sets up in practice in Toronto (but not granted a licence by the Ontario College of Physicians and Surgeons until 1880).

¹Ontarian events are marked with an asterisk.

- 1868 Adoption of a Code of Ethics by the CMA.
- *1869 Ontario Medical Act creates College of Physicians and Surgeons of Ontario.
- *1878 Formation of Toronto Medical Society.
- 1880 Foundation of New Brunswick Medical Society (now a Division of the CMA).
- *1881 Foundation of Ontario Medical Association.
Establishment of medical school in London, Ontario.
William Osler Secretary of the C.M.A.
- *1883 Public meeting under the auspices of the Women's Suffrage Club, Toronto calls for facilities for the medical education of women.
Establishment of Women's Medical College, Toronto, with an initial enrolment of three students.
Founding of a separate Women's College in Kingston affiliated with Queen's.
- *1887 Re-establishment of Toronto Faculty of Medicine, amalgamation with Toronto School of Medicine.
Establishment of Ontario Medical Library Association.
- *1891 Royal College of Physicians and Surgeons based on Kingston returns to status of Medical Faculty of Queen's University.
- 1893 Motion to disband the CMA because of "stagnation".
- *1894 Women's College at Kingston closed (no further women admitted for nearly fifty years).
- *1896 Women's clinic begun in Toronto (origin of Women's College Hospital).
- 1900 British Columbia Medical Association founded (now a Division of the CMA).
- 1901 Canadian Medical Protective Association founded.
- *1905 Saskatchewan Medical Association founded (now a Division of the CMA).
Coeducation begun at University of Toronto, Women's Medical College absorbed.
- 1906 Establishment of Alberta Medical Association (now a Division of the CMA).
- *1907 Founding of the Toronto Academy of Medicine.
- 1908 Establishment of Manitoba Medical Association (now a Division of the CMA).
- 1909 CMA incorporated by Act of Parliament.

- *1910 Opening of Women's College Hospital Toronto.
First issue of *Canadian Medical Association Journal* (formerly the *Montreal Medical Journal*, which, with changes of title, dated back to 1864).
- *1912 Passing of Canada Medical Act establishing Medical Council of Canada. Control of London, Ontario medical school passes from joint stock company to University of Western Ontario.
- 1913 First proposal to establish a national specialist-qualifying body (Royal College).
- *1914 OMA discusses instituting a Fee Schedule on a province-wide basis.
- *1918 Dr. T. C. Routley becomes part-time permanent Secretary of OMA.
- 1920 Beginnings of group practice in Canada, mainly in the Western provinces.
- 1923 Dr. Routley appointed first permanent General Secretary of the CMA, a post he combined with that of Secretary of the OMA.
- 1924 Newfoundland Medical Association formed (now a Division of the CMA).
- 1926 Formation (in Ottawa) of Federation of Medical Women of Canada.
- *1927 Ontario College of Physicians and Surgeons ends "reciprocity" with British General Medical Council.
Department of Hospital Service (forerunner of the Canadian Hospital Association) set up by the CMA.
- 1929 Royal College of Physicians and Surgeons of Canada founded.
- 1932 Beginning of Royal College examinations for Fellowship.
- *1935 Ontario institutes Medical Welfare Plan.
Opening of new Women's College Hospital, Toronto.
- 1937 Formation, in Winnipeg, of the Canadian Association of Medical Students and Internes.
- 1938 Associate Committee of the National Research Council set up to organize medical research.
- *1939 Federal constitution of the CMA achieved.
First woman resident in surgery (Toronto General).
- 1941 First woman to obtain Fellowship in surgery, Royal College.
- *1943 Resumption of admission of women to Queen's medical faculty after nearly fifty years.
Creation of Association of Medical Colleges of Canada.
- *1944 Introduction of Temporary (now Special) Register in Ontario.
- *1945 Establishment of Medical Faculty, University of Ottawa.

- 1951 Foundation of Trans-Canada Medical Plans.
- *1952 Introduction in Ontario of Educational Register.
- 1953 Provision made in CMA By-Laws for affiliation of National medical societies and their representation on the General Council, "to promote the unity of the profession".
- *1954 Founding of College of General Practice of Canada and of an Ontario Chapter of the College.
Joint Commission on accreditation of hospitals set up.
- *1955 Division of Postgraduate Medical Education set up by Toronto medical school.
- 1957 CMA establishes Canadian Medical Retirement Savings Plan.
- 1958 Founding of Canadian Council on Hospital Accreditation.
- *1960 Creation of (Canadian) Medical Research Council.
Canadian Medical Association Journal becomes a weekly publication.
ECFMG requirement for all "foreign" applicants for licensing introduced in Ontario.
- 1961 Royal Commission on the Health Services of Canada appointed. Chairman: Mr. Justice Emmett Hall.
Incorporation of the Association of Medical Colleges of Canada.
- 1962 "Medicare" crisis in Saskatchewan.
Appointment of first full-time Executive Secretary of the Association of Medical Colleges of Canada.
- *1963 Establishment of Hospital Medical Records Institute in Toronto.
- *1964 Premier announces creation of a new medical school in the province; to be located at McMaster University in Hamilton.
- *1965 First woman Director of the OMA elected.
Registration of all hospital internes under the Medical Act of Ontario becomes compulsory.
- *1966 Government of Ontario announces appointment of a Committee on the Healing Arts. Chairman: Mr. Ian Dowie.
- 1967 College of General Practice changes its name to College of Family Physicians.
- 1968 Formation of Federation of Provincial Medical Licensing Authorities of Canada.

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